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ABSTRACT

This practical guidebook for novice therapists is designed as a supplement to be used with courses or books which focus on therapeutic theories. The intent of the guide is to explore the practical problems encountered during therapy and to investigate the commonsense aspects and nuances of the therapeutic encounter. Numerous topics are covered, briefly, including a look at those entities known as "clients" and "therapists." Also explored are the therapeutic environment, including its physical organization and trappings, the therapeutic process from beginning to termination, and some viable alternatives to therapy. (Author)

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A Practical Guidebook For The Beginning Therapist

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CHAPTER I

INTRODUCTION

Most novice psychotherapists seem to be acquainted with at least one or more therapeutic theories or techniques. Often however these same beginning therapists lack an awareness of practical skills and methods to supplement this theoretical knowledge. Our intention is to deal with and explore the practical aspects of therapy which are just as important as a theoretical base for the full functioning psychotherapist.

The novice therapist should possess a broad based fund of information regarding therapeutic theories; however, this is not enough. Most therapists in the initial stages of their work with clients are quite anxious, but generally through the processes of client contact and trial-and-error these individuals discover and incorporate into their therapeutic styles many common-sence procedures. The scope of this book will be to allow the new therapist to bypass this often haphazard and cumbersome process. Thus, allowing the beginning therapist to feel somewhat more comfortable and prepared when faced with the already difficult task of therapy. In order to promote a "headstart" on this learning process, we will present information dealing with many of the nuances and intangibles of the therapeutic relationship.

This book will not stress any particular theory of therapeutic approach; rather it will deal with and focus on topics and areas which most books of theory exclude. If anything, the viewpoints presented will be quite eclectic. Essentially, this text should be utilized as a supplemental guide which has relevance to any beginning therapist whether he is of the (1) psychoanalytic school, (2) behavioristic viewpoint, or (3) humanistic school of thought. The book in general will deal with the work of the individual-oriented therapist, and the situations which he will undoubtedly encounter.

Topics To Be Covered

Becoming a "complete" therapist is a rather nebulous concept unless we operationally define what we mean by "complete." The authors firmly believe that being or becoming a "complete" therapist is more than being well-versed in a particular theory. The ability to spout jargon should not be and obviously is not equated with therapeutic proficiency. The pragmatic topics which this book will discuss will essentially define the characteristice of a theoretically "complete" therapist.

First, we will explore the unique qualities and characteristics of that entity labeled the "client." A better understanding of the needs, pressures on, behaviors, and expectations of clients will enable you to perform more responsively as a novice therapist. Secondly, in order to perform your functions as a therapist more effectively we will explore the qualities which tend to be associ-

ated with "good" and "poor" therapists. Thus, we will encourate a self-exploration of your personal needs, goals, and idiosyncracies which may have either positive or negative affects on your relationships with clients. In essence, we will encourage a better understanding of yourself as a "helping person."

Third, the authors will explain the complications, processes, locations, and also the simplicities of the therapeutic environment. A realistic viewpoint of where and how therapy can and will often occur is a must. And finally, we wish to impress upon the beginning therapist the idea that he will not always be the "key to unlock every doorway to the mind." The inexperienced therapist can do himself a great service by realizing that there are other avenues of treatment or alternatives to therapy. In many cases these alternatives may be far superior to the services which the novice therapist can render. Therefore, we will also explore some viable alternatives which the beginner might consider.

What is Therapy?

The term "therapy" implies many different things to different people. The theoretical viewpoint proclaimed by a therapist will usually shape his ideas and thoughts concerning his own particular concept of "therapy." The Committee on Definition, Division of Counseling Psychology of the American Psychological Association (1956), formally defined therapy as "helping individuals toward overcoming obstacles to their personal growth, wherever these may be encountered, and toward achieving optimum development of their personal resourcer." This is a rather non-theoretical, general explanation and should be viewed as but one definition of the complex concept of "therapy."

As previously stated the definition given to the process designated as therapy is usually shaped by the theoretical viewpoint of the definer. We will now present the definitions of therapy as defined from three popular theoretical positions: (1) the psychoanalytic school, (2) the behavioristic viewpoint and (3) the humanistic mode of thought.

Freudian theory or psychoanalysis best reflects the true characteristics of the psychoanalytic school of thought. The popular therapies hnown as Transactional Analysis and Primal Therapy are both variations of the psychoanalytic approach. However, they do reflect many of the classical or traditional methods of psychoanalysis. Psychoanalysts focus their attention on unconscious motivations, past experiences, and symbolism and their goal is to assist in the development of increased self-knowledge. This process is accomplished primarily by the psychoanalyst helping the client bring repressed anxiety-provoking memories into consciousness for the purpose of gaining insight into his actions and behaviors.

Diametrically opposed to the psychoanalytic school of thought is the behavioristic viewpoint. Such techniques as response shaping, aversive conditioning, modeling, token economies, implosion therapy, and behavioral contracting reflect this therapeutic approach. Behavior therapists base their therapeutic approach on the assumption that all human behavior, whether socially accept-

able or deviant, is learned. They hold that undesirable behaviors can be extinguished while appropriate responses can be achieved by manipulation of contingent rewards and punishments. Essentially, the behavior therapist assists clients in changing maladaptive response patterns with little or no regard for possible psychodynamic causes.

Finally, the humanistic or existentiol mode of thought is best reflected by Client-Centered Therapy, Existential Therapy, and Gestalt Therapy. The humanistic therapist acts as a guide with the client assuming responsibility for his own actions and the alteration of his maladaptive behavior. In general, humanistic therapists attempt to foster increased self-awareness, self-fulfillment, and a greater use of human potential. These therapists focus their attention on guiding the client toward a state of insight, self-confidence, and improved self-worth.

All three positions presented define therapy and the therapist's and client's roles differently. However, looking below the surface one can see the there is one important ingredient which stands out ——that the therapist is a "helping person," a "helper." This is one concept which the beginner must hold as paramount and always remember——"you are helping people!" Clients will be coming to you with a complexity of expectations, motivations, and problems, but all will be seeking "help" in some form or manner. Many therapists lose sight of this idea, and clients for them become speciment or burdens with therapy becoming a tiring, boring assignment. The remainder of this book will point out what "helping" can be on a very practical level in order that you might feel confident and well prepared to offer the best of services to your potentiol clients.

This guidebook will present a considerable amount of information that will be inclusive of the practical aspects of therapy. The reader must "keep-in-mind" that it is not and was not intended to be an exhaustive summary regarding the practice of therapy. Thus, the reader is encouraged to digest and use the material presented but is challenged to integrate these suggestions and observations with his own personal developing knowledge of the field of therapy.

CHAPTER II

The Client

All therapists, regardless of their stage of development, need to recognize that the process of therapy owes its existence to the client. Extensive volumes have been written about that unique entity called the "client." These books have attempted to explore, analyze, explain, and even sometimes condemn his behavior. Thus, if we are to define the very heart of therapy, it could probably be best summed up in this one statement, "therapy is for the client." It is for their benefit and their enrichment that we, as therapists, extend ourselves and become involved in their lives.

Diagnostic Categories

Anyone can potentially become a client. However, this label is generally not applied until an individual actively seeks professional help. Usually clients are experiencing some type of personal crisis. This crisis may be of a serious psychological nature or the result of a relatively minor environmental conflict. The beginning therapist must "keep in mind" that although the circumstances producing the crisis may be common to many people, each client will uniquely experience those circumstances. Thus, the concept of crisis means different problems for different clients, and the beginning therapist should take care not to minimize each client's personal crisis.

Often, people seek professional help because they need assistance in order to make an important decision. The decision-making may be either of a simple or complex nature, but the client's inability to decide may have debilitating effects upon his day-to-day functioning. The therapeutic process may involve active guidance, reassurance, or acting as a "sounding board" for the client's ideas. However, at times the client's capability to make a decision is beyond his immediate control because he cannot always control the people and events in his environment. Thus, in situations such as these (loss of job, divorce, or any incident causing trauma or excessive concern), the individual is usually viewed as having adjustment difficulties. To aid the client in overcoming these difficulties, the therapist may present the possible alternatives to a seemingly hopeless situation.

Some people will seek professional help because they are experiencing difficulties dealing with the significant individuals in their life. Often these persons will blame others for their problems, when in reality they frequently have a distorted view of others' responsibilities to them. Poor interpersonal relationships usually reflect inner tension and the behavior manifested can range from unhealthy withdrawal to hostility toward others.

The therapist may assist this client by exploring with him (1) his interpersonal needs, (2) his views concerning himself and others, (3) his expectations regarding others, and (4) by being an appropriate model regarding interpersonal relationships.

One extreme client population that might be encountered is the group diagnosed as psychotic. Persons are described as being psychotic when their abilities to deal with the demands of life are grossly impaired. Hence, these individuals' ability to "reality-test" may be characterized by such aberrations as hallucinations, delusions, or extreme mood swings. The impairment called psychosis can be due to a number of causes. These causes may range from brain damage to a type of environment which predisposed the client to psychosis. The client who displays psychotic behaviors can seem overwhelming to both beginning and experienced therpaitst. To treat or help this individual will often require more help than the beginning therapist has to offer. Therefore, the therapist should utilize fully the resources available in the therapeutic community to either assist him or to assume responsibility for the treatment of the client.

Another label for people seeking help is neurosis. These clients often find it extremely difficult to deal with the inevitable stresses in modern day life. The significant symptom is anxiety which may relate to one or many dimensions in their lives. These clients, either by inclination or training approach life in a fearful and worrisome manner. In general, the majority of people coming for therapy will be classified as neurotic, and they will bring with them a host of irrational beliefs. Treatment of such clients may range from an exploration of past events and experiences (analysis) to a systematic elimination of symptoms (behavior modification). Within this broad category characterized by anxiety are individuals who are plagued by very specific and excessive fears which are diagnosed as "phobias." Fears of such things as height, open spaces, germs, etc. can present extreme difficulties for the individual which may or may not disrupt other aspects of his life. Many phobics devise unique strategies for dealing with anxiety-provoking situations and usually these strategies invlove some type of avoidance procedure. Therapeutic techniques for this problem may also range from exploration to symptom modification.

One of the most widely discussed and profound problems in mental health is depression. Usually the depressed client is characterized by feelings of fatigue, hopelessness, and low self-esteem, while sometimes manifesting also feelings of helplessness and guilt. The depressive state may range from a neurotic depression to a psychotic depression. The neurotically depressed are usually in touch with reality and able to function adequately but with diminished enthusiasm and drive. Most neurotic depressions are caused by situational occurrences, such as, the loss of a loved one, failure in business, or divorce. If a client is unable to effectively deal with the depressive episodes in his life, then the more serious condition of psychotic depression may result. Treatment for the depressive states may range from verbal encounters to the more medically-oriented modalities of chemotherapy or electro-shock therapy.

A severe consequence resulting from the depressive state may be suicidal ideation. Many times this ideation may be confined to the realm of fantasy; however, it may also lead to suicidal gestures and/or attempts. Suicidal gestures are usually not life-threatening but are intended as means to attract help or attention. On the other hand, an actual suicidal attempt is a well-calculated and well-planned procedure to take one's life. Behavioral clues to look for may include the following, and affirmative answers to these clues may increase the probability of an attempt:

1) Has the client attempted before? If so, were the circumstances similar to the ones he is experiencing now?
2) Does the client have a difinite plan - that is, has he decided on a fairly detailed way to go about it?
3) Does he have the means to harm himself?
4) Has he written a note to significant others?
5) Is there a lack of people close to him that he could possibly confide in if he felt an impulse that he could not control?
6) Do you, as another human being, have a "gut level" feeling that the person talking to you would actually kill himself?

In our culture, therapists often encounter individuals who are self-destructive in ways other than overt suicidal attempts. Drug and alcohol abusers are examples of such self-destructive individuals who often come to therapy. Indeed this is one of the most widespread problems encountered by contemporary mental health providers. Identifying and dealing with this problem area are important functions facing the therapist. Drug abusers (and we include alcohol under the general category of drugs) present a variety of behaviors to the observer. Besides the obvious and often incapacitating physical problems, there are usually difficulties in handling stress, excessive anxiety, feelings of inadequacy, and continuing conflict with significant others. Drug abuse is such a complex problem that treatment will probably be of a multi-faceted nature. Therefore, the beginning therapist needs to be aware of the integral part that he may play in the treatment plan. His role, may involve such activities as 1) consultation with physicians regarding emergency treatment; 2) coordination of treatment with allied professionals; 3) consultation with significant others (family, employers, etc.) regarding the institution of milieu therapy; 4) primary giver of therapeutic treatment; or 5) as educator or referral source.

Family conflicts have been a part of our society and other societies since the inception of history. Usually these conflicts center around the relationships between family members and/or outside influences which may affect the family unit or individual members of the family. If the family is experiencing a crisis situation, then it is safe to assume that most or all of the family members are also placed under varying amounts of stress. These difficulties may range from minor irritations with other family members to very severe emotional problems that might be precipi-

tated by family conflicts. Although the family appears to be simple in its physical structure, it is an extremely complicated psychological system molded by a complexity of individual needs and social roles. An inherent quality of the family system, as in all systems, is its resistance to change. Therefore, family therapy, of necessity, is a specialized intervention technique. The beginning therapist must realize that family therapy is an extremely difficult therapeutic procedure. Therefore, the novice therapist, if not well-versed in this area, would be well advised to seek consultation or consider referral.

Marital counseling is an ever increasing therapeutic modality which parallels family therapy in its complexity. Like family therapy, marital problems can also range from minor to extremely severe. Marital counseling focuses on the relationship of the marriage partners and deals specifically with mutual problem solving. Marital dysfunction can result from a number of problems, such as, incompatibility, a lack of concern for the partner, different life styles, or any situation which is of significant conflict and disrupts the marriage. Marriage counseling, like family therapy, also requires considerable knowledge of specialized techniques. Once again brash intervention without proper training or direction may prove harmful to an already fragile relationship. The beginning therapist, who is not trained in this area, should proceed cautiously, seek consultation or consider referral.

Another category of clientele frequently seen would be those experiencing psychophysiological reactions. The presence of physical symtoms or ailments not organic in nature but due to underlying emotional difficulties would be termed a psychophysiological reaction. Such manifestations as migraine headaches, skin eruptions, stomach and digestive disorders, temporary blindness, or paralysis of an extremity may be symptomatic of this disorder. Usually, this physical-emotional process is goal-directed, in that, the client seeks to achieve gratification which he perceives as being unavailable to him through more rational means. This process can be seen in the child who wishes to avoid a spelling test at school -- he developes a sudden pain in his stomach. Many of these clients are merely seeking attention, special consideration, or avoiding anxiety-provoking situations. Therapy with this client is very difficult and can be reasonably approached as a three-fold process. The therapist must first assist in the relief of symtomatology (referral to medical doctor may be mandatory at this point). Next an exploration and understanding of the underlying conflicts which may have produced the symptoms needs to be carried out. Finally, realistic and rational alternatives for resolving conflicts should be explored. This particular psychological problem may involve a vicious cycle, in that, successful medical treatment may reinforce the concept that causation is totally organic, which may result in a reluctance to deal with psychological aspects.

Individuals who exhibit maladaptive behavior that differs in severity from both psychosis and neurosis are often viewed as having personality disorders. This type of disorder is characterized by a long-standing, deeply ingrained personality disturbance

of either an intra- or interpersonal nature. There are many psychiatric categories defined as being personality disorders, but we will focus our attention on three such categories which most counselors will frequently encounter.

The inadequate personality seems destined by his own admissions to failure in just about every area he undertakes. His self-concept is very low and usually he is the type of person who cannot motivate himself internally. This person will come into counseling with a myriad of difficulties, but they will all relate to the central problem of his feeling of helplessness and inadequacy in almost every life situation. Treatment would involve an initial period of exploration and understanding of his motivations. Following this, the therapist would need to assist the client in directing his energies toward implementing those activities that will prove to the client that he is capable of adequate behavior. The beginning therapist must be aware that his primary focus should be on the main problem of inadequacy not peripheral symptoms often associated with this problem.

Another type of personality disorder is the passive-aggressive individual. These clients deal with their frustrations and aggressive feelings by adopting a passive stance. The aim of this passive stance is to release aggressive feelings and lessen the probability of reciprocal hostilities. Such acts are sometimes subtle, often socially-condoned behaviors which may be well-calculated or so deeply ingrained as to be performed in an automatic manner. Such behavior is usually seen in threatening situations, and the end result of this passivity is that someone is affected in a negative manner.

Examples of passive-aggressive behavior might include the following: missing appointments; procrastination; conveniently forgetting to perform certain acts; requiring excessive, inappropriate explanations from others; or even stubbornness. Treatment must involve a rechanneling of these aggressive feelings to a more effective and helpful style of coping. To do this, a reeducation of ways to deal with frustration and hostility is necessary. This reeducation process can take many forms, one of which may be assertiveness training. The novice therapist must be aware that the passive-aggressive individual may resort to the above tactics while in therapy. These tactics should be viewed as habitual responses of the client and not necessarily as personal attacks on the therapist. If the therapist finds himself becoming angry, he may want to check out these feelings of the client.

The final personality disorder that we will discuss is the anti-social personality. These individuals are basically unsocialized and release their frustrations and hostilities in an overt manner. Their maladaptive behavior patterns frequently bring them into conflict with society, and generally they do not feel guilty about their behavior nor do they seem to gain value from punishment. We do not wish to bias the beginning therapist's attitudes regarding the anti-social personality, but the novice must be aware that such clients generally do not profit from therapy. A relationship of trust is extremely difficult to establish with these individuals, and many fail to see how their attitudes can be harmful to both themselves and to others. If a relationship of

trust is established, therapy will center on reeducating the individuals as to the values of society. These clients will not be hard to recognize because they are usually court-referred or have a long history of anti-social acts.

The final category that we will discuss is the individual who is having difficulty in adjusting to an overwhelming environmental stress. These difficulties can be viewed as transient and there is usually no underlying mental disorder. Usually with these types of problems, there is a clearly discernible cause. Situational adjustment problems are not limited to a particular stage of life; they can occur in infancy or in later life. Some examples of typical adjustment problems are:

1) The birth of a sibling triggers enuresis in a preschooler;
2) A child may experience school phobia because of a stressful classroom situation;
3) A teenager experiences rejection by his peer group because he won't use drugs;
4) A middle-aged businessman feels inadequate because a younger man was promoted over him;
5) Retirement poses a threat to a 65 year old man who has no other interests outside of work.

Treatment may involve one or many sessions and the therapeutic techniques may range from non-directive listening to actively manipulating the person's environment.

All of the aforementioned categories may be helpful in allowing the new therapist to understand at a basic level exactly what problems he will encounter in a face-to-face therapy situation. The symptoms discussed in these categories are presented as guidelines only, and will not necessarily run true in every client. Some clients will manifest a cluster of symptoms that cannot be easily categorized. To think only of labeling and diagnostics in the formal sense may not be in the best interests of the client. The formulation of a very complicated diagnostic label may be heart warming to the therapist but may be of little value in the treatment of the client.

It can be seen that the symptomatology exhibited by clients might be important in terms of professional communication, but the therapist must remember that clients are first and foremost seeking "help." The symptomatology should be viewed, in our opinion, as a way of assessing the particular needs, strengths, weaknesses, and motivational states of clients.

Preconceived and Real Characteristics of Clients

Preconceptions of the therapist and actual client characteristics will tend to influence the manner in which the therapist approaches clients. Therapists' initial impressions regarding clients are greatly shaped by their theoretical viewpoint, and one therapist may view a client differently than another. For example, a client who is seen as a "patient" may be thought of in medical terms only, and that therapist may seek primarily medical solutions. However, the behavioristic therapist after considering and ruling out physical complaints will probably stress a relearn-

ing process as opposed to medical solutions. Not only will his type of theoretical inclination determine how he labels the behavior he sees, but it may also shape the types of behavior and verbalizations that he will draw out from the client. Both novice and experienced therapists should be continually aware that their biases, both positive and negative may influence the therapeutic interaction.

After the therapist has integrated his initial impressions of the client, a process of gathering identifying data is usually undertaken. Usually client characteristics range from the obvious to the discreet and may vary in importance. Often some clients are preceded by an extensive array of background information which may or may not be of value. In some cases, the therapist may want to either confirm or negate this information using his clinical judgment to determine if this information is relevant in the present circumstances.

The therapist's first impression of the client will be influenced by those characteristics which are unique to that individual. These physical and social characteristics can obviously influence the therapist both positively and negatively, and they may cause either drastic or subtle changes in his attitudes and/or behaviors which are directed toward the client. One example from the myriad of client characteristics which can influence the therapist is race or ethnic origin. An awareness of an individual's feeling towards other ethnic groups is especially important. Suppose a white therapist accepts a black as a client. If the therapist is not prepared to accept blacks as part of society, he is certainly ill-equipped to accept them as clients.

There are many other client characteristics which can also adversely influence a therapist, such as: 1) the client's level of education, 2) his intellectual ability, 3) religious preference, 4) sex, 5) occupation, 6) physical handicaps, and even 7) the client's "life style." In addition to the negative influences, the therapist also needs to guard against overly identifying with the client. This type of situation could inhibit necessary confrontations and challenges to the client's thoughts and behaviors.

Knowledge of client characteristics can help you to more fully understand clients, but therapeutic gains are best realized when the therapist can put aside his own emotional biases and truly be empathic with clients. As previously stated in Chapter I, this statement reinforces the concept that the therapist is first and foremost a "helper" and must focus his attention on the client as a unique individual.

Reasons for Referral

The majority of clients referred for therapy are sent by other "helping" professionals, agencies, family members, or friends. Examples of individuals who refer are: medical doctors, ministers, educators, lawyers, judges, police, welfare workers, husbands or wives, parents, former clients, and professionals working in an agency setting. Probably a minority of clients are those who refer themselves. This person usually is in need of help and has the foresight to realize he can seek help from someone trained in therapy. Most people who present themselves for therapy come of their own free will, which means that they may

terminate contact at anytime. However, a category of clients commonly referred to as "forced-referrals" often do not have the opportunity to exercise this option. This process usually occurs when an empowered agency refers an individual who needs specialized help, but some agencies view this referral as punishment rather than treatment. The beginning therapist must be cognizant that this type of referral may cause the client to have a strong negative attitude toward the helping process. Agencies or groups which frequently make "forced-referrals" are: the courts, police, schools, and even families.

It is important to mention at this point that the tone of the whole therapeutic process can be set by the type of referral that is made. If the referral was made in a friendly, positive manner, the client may have positive expectations. He may then use these positive expectations to produce some therapeutic gain. Usually this type of facorable atmosphere is in itself an important curative factor in aiding the client and helping him realize his goals. If the referral is a forced referral and is made in an atmosphere of indignation and resistance, the therapist will usually find there will be difficulity in gaining rapport. This client often does not even realize why he is in therapy: Feelings of hostility toward the referral source and you will often preclude any type of therapy, and indeed, the client is often there simply to serve out his sentence or punishment. The novice therapist should be aware that there are both positive and negative aspects of the referral process, and the therapist must strive to maintain a smooth transition from referral to therapy.

How Client May View Therapist

As it is important to discover some basic identifying data about the client, it is also important to know how the client may view and identify the therapist. That is, the client's view of the therapist is also essentially important to the therapeutic process. If the therapist is perceived as being friendly and accepting, then the client will tend to view the therapeutic encounter as a helpful one.

The issue of transference is important when considering client-therapist's relationships. We do not define transference in a strict psychoanalytic sense, but simply see it as the tendency for a client to respond to a therapist in a biased manner because the therapist reminds the client of some important figure in his life. Colby (1951) has defined five types of transference which we will list and discuss:

1) The therapist as a giver of affection. The client views the therapist as a nurturant person whom he hopes will meet many or all of his needs.
2) The therapist as a powerful authority figure. In this case, the client sees the therapist as an infallible, "all-knowing," leader, one who will be an all-pervasive healer of the client's ills.
3) The therapist as a teacher or ideal model. In this situation, the client may view himself as a student who has much to learn from a more knowledgable teacher. Also, some clients may regard highly the

therapist's behavior and "life style" and try to imitate these behaviors or characteristics.

4) The therapist as a rival. Some therapists may be perceived as competitive, threatening, and/or aggressive. These biased feelings probably stem from the client's aggressive encounters with significant others in his past.

5) The therapist as a favorite child. These clients regard therapists as individuals who are deserving of their overwhelming affection and protection. However, this may inhibit the therapeutic process because the therapist may not be taken seriously (children cannot correct parents).

These are rough and broad guidelines for the beginning therapist and should be considered as starting points on which to base a therapeutic approach. Clients may manifest one or a combination of the aforementioned concepts, and in their extreme can be quite debilitating to therapy and should be given immediate therapeutic attention.

Summary

In this chapter we have tried to present an overview of the types of individuals who come for therapy. In the section dealing with diagnostic categories, we pointed out some of the "labels" which may help the novice therapist to better understand clients, and we also explored the reasons as to why individuals often seek professional help. This chapter also dealt with how therapists may view clients, and also how clients may view therapists. In addition, we have stressed how the attitudes of these two parties are critical to the therapeutic encounter. A final area of concern involved the uses and abuses of the referral process. This chapter and the next chapter will deal with the client's counterpart--the therapist.

CHAPTER III

The Therapist

We have taken an in-depth look at the different types of clients which you might be encountering as a therapist, and the multiplicity of goals, desires, and expectations which these prospective clients may manifest. This chapter will focus attention on another important member of the therapeutic relationship--the therapist. We will also explore both the negative and positive characteristics of therapists and look at the qualities that are often found in the "good" therapist.

What Is a Therapist?

The role of the therapist can be defined in numerous ways and will usually reflect his theoretical viewpoint. In Chapter 1, we explored the theoretical goals and methods of action proclaimed by three therapeutic schools of thought and defined the roles of these therapists. We will now review the defined roles which seem to be characteristic of therapists from the psychoanalytic, behavioristic, and humanistic schools.

The psychoanalytic point of view breeds therapists labeled as analysts or psychoanalysts; the behavioristic approach would seem to produce therapists who analyze also, but their role is probably best characterized as a technician or technologist. And finally, humanistic therapists tend to view their role as one of guidance. All of these roles are not static; and in most cases, therapists at some time will assume all of the roles. The educational exploration of therapeutic roles may be quite intriguing and baffling to students of therapy, but generally the client is not concerned with these educational philosophies.

In Chapter 1, we indicated that the three aforementioned theoretical viewpoints have a singular theme-- help for the client. The layman who is seeking psychological help would probably define the therapist as "someone who is going to help me." This definition borders on the inaccurate, in that, the therapist, regardless of his theoretical background, will offer help but he will not change the client. If the client desires behavioral or psychological change, the therapist will offer help via active listening, exploration, analysis, guidance, advice, behavior modification, etc. However, if this desire on the client's part is to become reality, then the client must initiate change. As Dr. Maxie Maultsby (1975), a behavioristic psychiatrist, states, "no method of counseling works unless the person being counseled decides to use it." This is a point which should be kept in mind and will be further covered later in this chapter.

Therefore, one can easily see that therapists define their roles in many, many ways, and we have merely dealt with three formal definitions. Such factors as theoretical background, location of work, and therapeutic activities will generally shape

one's definition of the therapist's role. There are many types of therapists, and some are not necessarily concerned with verbal interaction. This text focuses its attention on the individual therapist, but other specializations include:

1) Group Therapy
2) Marital Counseling
3) Family Therapy
4) Speech Therapy
5) Hypnotherapy
6) Chemotherapy
7) Rehabilitation Counseling
8) Occupational and Recreational Therapy
9) Music Therapy
10) Art Therapy
11) Physical Therapy

All of these therapeutic approaches outlined can have a tremendous influence on a client's mental health and behavior. One can also see that there is a wide range of differences as to therapeutic methodology with each defining their therapeutic roles in unique ways based upon theory, location, and methods.

Who Can Be a Therapist?

The number of potential therapists which the client can encounter may seem nearly limitless, and we will now examine the continuum of therapists, ranging from the professional to the amateur. Figure 1 depicts what we define as the "therapeutic triangle." At the top of the therapeutic triangle undoubtedly would sit the best known professionals: psychiatrists and psychologists. Educationally, these professionals probably deserve this top billing. The psychiatrist, of course, possesses a medical degree and a specialization in the field of psychiatry. He, theoretically, is a most "complete" therapist for he can treat both the emotions and the body. The license to prescribe medications has been the primary factor in earning the psychiatrist this lofty position.

Slightly below the psychiatrist in prestige and authority falls the doctoral-level clinically-oriented psychologist. He is not licensed to prescribe drugs, but generally, he has experienced as much professional training as a psychiatrist in non-medical areas. He usually is highly trained in therapeutic techniques, testing, and research. Also, he is usually licensed by a state board of psychology to practice therapy. This level psychologist is often given the additional duty of supervision of masters-level psychologists, other non-medical professionals, and para-professionals.

Another group of professional therapists is represented by those individuals who hold the masters degree in Clinical Psychology and Social Work. The masters-level psychologist is also trained in therapy, testing, and research, but they have not invested as much time or study as have doctoral-level psychologists. The MSW is also highly trained in individual therapy and often specializes in group processes. In addition, these individuals also are often certified or licensed to practice therapy.

On the third layer of this therapeutic triangle would sit

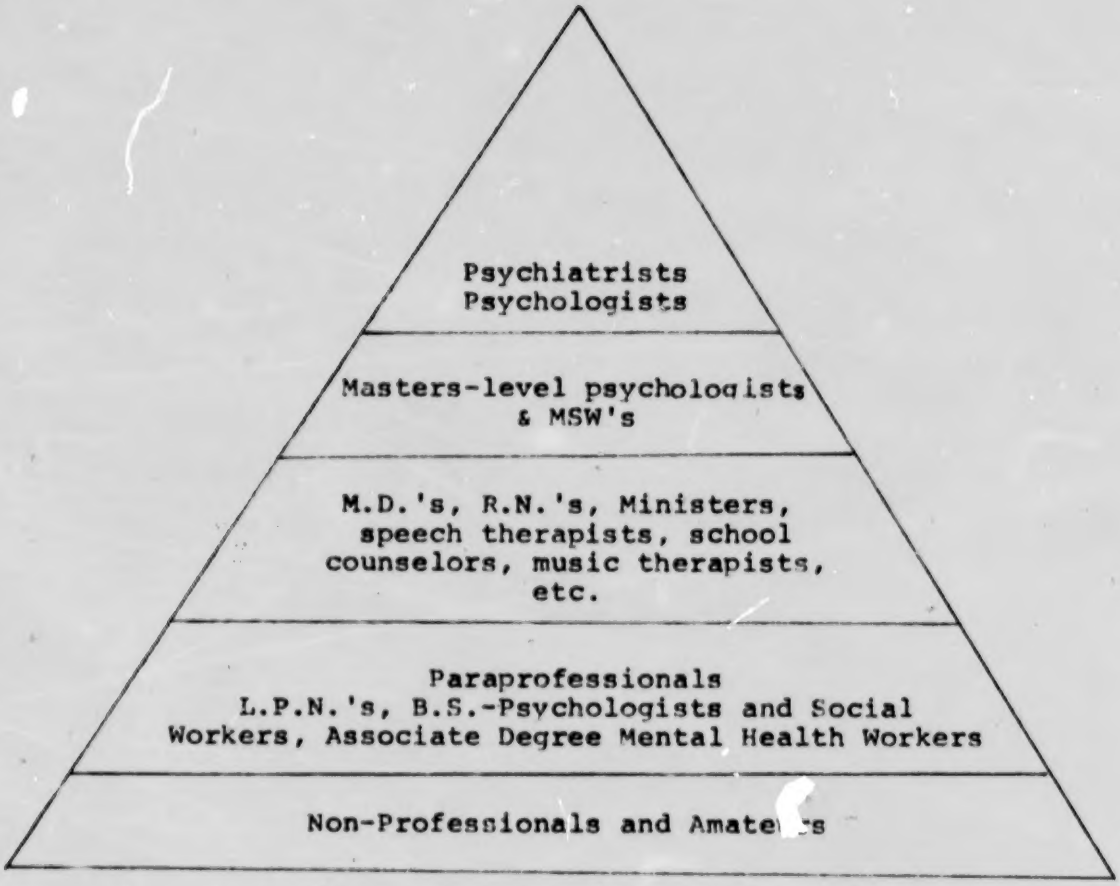


Figure 1: The therapeutic triangle

other professionals and borderline professionals who may be highly qualified educationally and who may also be minimally qualified to engage in therapy. Some of the individuals comprising this group might be medical doctors, ministers, Registered Nurses, speech therapists, rehabilitation counselors, physical therapists, occupational and recreational therapists, music and art therapists, or elementary and secondary school counselors. Unfortunately, most of these individuals who carry on therapy or counseling are not supervised and are not required to be sanctioned by a state agency to practice counseling.

The fourth level of our triangle is comprised of paraprofessionals, those individuals whose work parallels that of professionals although they do not hold advanced degrees and usually have limited counseling skills. Such professions as Licensed Practical Nurses, bachelor-level psychologists and social workers, nurses aides, teachers' aides, welfare workers, food stamp workers, and associate degree mental health workers would fall into this category. In general, most of these individuals work in supervised positions and require close supervision.

The base of our triangle is filled with non-professionals who offer advice and counselling. Such individuals as wives, husbands, friends, bartenders, or relatives fit this category. Usually, these people have bare minimum knowledge of therapy and counseling, and often seem to offer counsel based upon gut-level response and experience. Sometimes psychological assistance can be received by an individual from the suggestions, advice, and active listening of the non-professional.

Some professionals and laymen are of the opinion that any therapy or counseling carried on by any individual, professional or amateur, is good for the client. This belief could not be further from the truth. Truax and Carkhuff (1967), have reported that all therapy is not helpful, and in fact, some therapists can and do exacerbate psychological problems. This situation will be dealt with in more depth later in this chapter.

We have surveyed in some depth the idea of who can be or often acts as therapists. However, this text will primarily deal with those individuals whether they be professionals or paraprofessionals, who are actively pursuing academic or professional training in the area of therapy. Thus, this leads us into our next major topic.

Why Do People Become Therapists?

People become counselors or therapists for a variety of reasons. These reasons can be of either a positive or negative nature, and we will look at some of the primary factors from both.

The most obvious reason for becoming a therapist and the most noble is that the potential therapist has a genuine concern for the welfare of others and desires to "help" others. This is a fine characteristic and should be driving force behind all therapists. Other reasons for entering the field might be labeled as "selfish needs." These factors would be of a "self interest" nature and involve such reasons as: (1) money, (2) prestige, or

(3) self-growth. The authors do not wish to imply that these reasons are necessarily negative or detrimental to the development of a "good" counselor. Rather, the full functioning and most effective therapist is probably motivated by a realistic mixture of both self-serving interests and genuine concern for others. In fact, these "self interest" factors previously noted often can motivate the therapist to greater heights, intellectual growth, and therapeutic excellence.

Unfortunately, there are also many people motivated by rather negative factors to become therapists, and we will now explore some of these types of reasons. You might recognize some of these factors as motivating you to become a therapist. If you do, then we recommend that you make some effort to explore and fully understand these negative characteristics for they can only damage your efforts as a therapist.

One negative role that some therapists assume is that of "judge and jury." Essentially, these persons have entered the field to judge the behavior and acts of others. These people wish to apply their moral standards to others, and thereby believe that they can label clients as being either "good" or "bad". However, by-and-large, most therapists should not assume this judgemental position, for you job is usually to separate the "deed from the doer." You should strive to be as empathic as possible and remember that you as a therapist should accept this individual for what he is, not what he does. The client, like you, is a fallible human being and "you are not God - nor a near relative" (Colby, 1951).

Another negative motivation for becoming a therapist which parallels the one just discussed is the need to feel superior. This therapist sees himself as the authority on human behavior. He believes that he has the authority to interpret behavior and make the definitive statement on that behavior. Therefore, he believes that his abilities are of a superior nature. An example of this negative characteristic might be the freshman college student enrolled in a general psychology course who begins to interpret everyone's behavior and who very quickly becomes obnoxious. In essence, this freshman and this type therapist are playing a game entitled, " I know something about you that you don't know." Both are making it clear that they believe that only they understand another's behavior. They believe that this individual is not capable of understanding his own behavior, and thus deprive him of the right to actively pursue self-improvement.

A third "bad" reason for becoming a therapist is to enter the field to establish yourself as the norm, that is, if you look, act and talk just like me you are probably normal. Often times the therapist may consciously or willingly set himself up as the model for the client to pattern himself after. The therapist who fails to recognize that each client must establish unique personal norms is not allowing that client to experience personal growth.

This situation leads readily into a fourth area of concern; that is, the label of therapist does not imply normality, only that the individual has experienced academic training. There is a fringe group of therapists who are in need of psychological

counseling and who have avoided seeking professional help. These individuals have chosen to experience self-growth and psychological help through their study of psychology and psychotherapy; thus, bypassing the most advantageous method of treatment. Some of the members of this fringe group will experience growth, but others will be so emotionally entangled in their own problems that their effectiveness as therapists will be eroded. These persons also can lay claim to a false sense of "normalcy" because they carry the title of "therapist."

Is All Therapy Helpful?

This topic was touched upon earlier in this chapter, and the answer to this question is -- NO! All therapy is not helpful to clients. In fact, some therapists, clinics, and institutions can be harmful. Truax and Carkhuff (1967), in their review of counseling literature and research, state that the evidence now available suggests that psychotherapy may be harmful as well as helpful. Counselors and therapists have most often assumed implicitly that although they could be helpful, they would rarely prove "psychonoxious" as contrasted with psychotherapeutic (Truax and Carkhuff, 1967, p. 20).

Obviously, potentially harmful therapists might include individuals reflecting disinterest, hostility, incompetence, or personal emotional difficulties. It is also possible that a helpful, productive therapist may be exacerbating the client's problems by not using common sense. Psychotherapy can be quite counterproductive in some cases. For instance, some therapists might be so involved in instituting therapy that they fail to attend to the client's real or immediate needs. Just because someone is referred to you, that referral does not always imply therapy. The client's problems may stem from non-psychological factors. One client's behavior may be quite strange and unusual because he has a brain tumor, or another client may be manifesting similar bizarre behavior due to a psychological disturbance such as schizophrenia. In both cases, fruitful therapeutic work will not properly proceed unless the clients' immediate needs are recognized and understood. In the first case, referral to a brain surgeon would obviously be most appropriate, and medication for the schizophrenic will need to be administered prior to any attempts at therapy. As for the brain tumor case, following a successful operation, you and your therapeutic techniques may not even be needed or wanted. Regarding the Schizophrenic, therapy is warranted, but if the client is totally out-of-touch with reality, therapy will be useless unless the client is properly medicated prior to instituting treatment.

Some clients will be temporarily upset or depressed because of a particular situation which has disrupted their lives. Some of these clients may need counseling to help them better cope with the demands and pressures of life. However, in other cases a reality-oriented alternate action might just be the best approach. An example of such a situation follows:

> A college senior beginning his last semester of academic work suddenly loses his job. He was dependent on his

former job to pay his college expenses for he is an only child living with his disabled and widowed mother. He will need to drop out of school for he and his mother barely got-by on the money that he made and that she receives from the government. He comes to you, the college counselor, manifesting depression, feelings of helplessness, and confusion. He has no history of psychological disturbances, and he generally is viewed as a well-adjusted college student. One could begin therapy with him focusing on the ups and downs of life and his need to learn to cope with life and its pitfalls. Realistically, that therapist is wasting his and the college student's time. The therapist in this case, after a careful evaluation, should probably seek out an alternative to therapy. He reassures the young man that financial aid can be obtained through the college, and he refers the young man to the appropriate office. Also, the therapist refers the student to the college placement office for assistance in finding another job. The therapist keeps in close contact with the student and the financial aid and placement offices to insure that everything goes smoothly. The student receives a grant which he could have received long ago because of his family situation, and he is scheduled to interview for a job the following day. Within a few hours his life looks brighter and the feelings of depression, confusion, and helplessness have dissipated. In this case, the therapist using some common sense helped the student using an alternate action and more appropriately met his needs.

Yes, therapy can be harmful and/or counterproductive and there is no hard-and-fast rule to follow in determining this situation. To stay on track professionally, the authors recommend that you strive to evaluate your behavior with clients. Ask yourself constantly the question, "Is this action in the best interests of my client or am I really primarily meeting my own needs?"

Characteristics of "Good" Therapists

This section will deal with what we define as the typical characteristics of "good" therapists. Others may disagree with our list; while some might add to the list. Overall, the characteristics which we present are eclectic, drawn from many schools of thought. However, we believe that responsive, full- functioning therapists should possess most, if not all, of the traits to be described.

A body of scientific knowledge concerning psychology. Many individuals can carry on good but speculative dicussions concerning human behavior with little or no scientific evidence to back up their opinions. However, the well-grounded therapist should have a fund of knowledge based upon the research of psychologists and other behavioral and social scientists. This body of knowledge should include information dealing with (1) the foundations and theories of psychology, (2) research and experimentation, (3) ethical concerns, (4) the psychological schools of

thought, (5) developmental theories, (6) the practice of psychology, and (7) the different therapeutic viewpoints.

A fund of knowledge regarding normal and abnormal behavior.

The definition of normal behavior is quite nebulous. One researcher might define normality as lying ± 1 standard deviation above and below the mean on a bell-shaped curve. Another researcher might define normality as an absence of abnormality. Neither approach is very clear or accurate. Sometimes we humans believe that if someone behaves just like us, then they are normal obviously establishing ourselves as the norm. This definition also is quite inaccurate. Information concerning normal and abnormal behavior can only be obtained via hard work and exploration. The potential therapist needs to read and study relevant publications, and he also must experience through interaction the world of normality and the world of abnormality. The therapist must not isolate himself from society; he must become an integral part of his environment. Also, the novice therapist must seek out formal and informal practical experiences with these individuals labeled by our society as abnormal. The two areas of investigation should work hand-in-hand to allow the therapist to more thoroughly understand human motivation and behavior. Additionally, the budding counselor must constantly be exploring through education the personality patterns which he and others around him manifest, looking at these patterns in a critical manner.

Sensitivity to detect and properly evaluate normal and abnormal behavior.

The culmination of the work outlined in the previous section would hopefully lead to a sensitivity for detection of both normal and abnormal behavior. However, the "growing" therapist is generally always learning, and this sensitivity of which we speak is fostered. As with any skill, continued practice and reevaluation is needed to keep this type of sensitivity in tact. A therapist will also realize that this sensitivity may be affected by his level of emotional involvement. The following example may be utilized to illustrate this point:

> You have an uncle who drinks excessively, but you have not confronted him or really dealt with the idea that he is an alcoholic. You have learned to essentially ignore his behavior. A client comes to you complaining about his wife and their relationship. His drinking pattern is similar to your uncle's, but you know from your personal experience that your uncle and aunt are happily married. Therefore, the drinking issue is totally avoided as a possible cause of marital maladjustment.

This therapist demonstrates that his sensitivity in this area is obviously biased. He would do well to refer this type of client to others until he is better able to understand his own feelings in this area.

Well-rounded background.

The therapist will be coming in contact with individuals from all walks of life and with many different areas of interest. The therapist needs to be familiar with his world and interested in more than just a narrow band of ideas. Why is this recommended?

To more thoroughly understand or empathize with a client, one might need to know at least a minimal amount about his work, hobby, life style, etc. For example, a frustrated tournament chess player who is having some marital difficulties comes to you for assistance. The therapist who has utterly no interest in chess may see little connection between marital problems and a silly, little game. The therapist, who at least reads his daily newspaper, might quickly see some connection between the two. The intensity with which a Bobby Fisher or Boris Spassky plays and the frustrations and emotional involvement of tournament players are well-documented.

Also, therapy may need a catalyst to create an air of trust and understanding. The therapist who can relate experiences common to those of the client or at least minimal knowledge about some aspect of the client's life may be providing that needed catalyst.

An awareness of personal characteristics and their influences on therapeutic style.

What this characteristic boils down to is, "do you as a therapist have some 'hang-ups,' qualities, or idiosyncracies which may be hindering or destructive to your therapy sessions?"

Perhaps you might have even chosen a particular therapeutic approach which fits your personality. A very reserved, unassertive individual might avoid directive therapies and their consequent strategies. This therapist may feel threatened by people, and he may be frightened to assert himself and confront clients with anxiety-laden data. Instead of reflecting the true nondirective approach, this therapist has modified the approach to meet his personality needs. Constantly explore your own personality to better understand your actions and behaviors and also constantly strive to improve your personality through training, study, and perhaps even through therapy.

Commonsense.

All therapists need a good dose of this. Commonsense is fostered by practical experience, maturation, and by being an integrated member of society. Also, commonsense sometimes is influenced by your humanism and compassion. Above all, commonsense is shaped by a sincere interest in the client, his problems, and needs; while keeping in mind that client's best interests at all times. Frequently, some professional therapists are called on to administer psychological tests. Test interpretation is an area of great concern among psychologists today because test results have often been misinterpreted and misconstrued. Many testers have abused their privilege by (1) not using commonsense, (2) misinterpreting test data, and (3) improperly labeling or evaluating clients. An exaggerated example might be:

> A college-educated adult has sought counseling at the local mental health clinic. Following a battery of tests, the tester finds that the client has an I.Q. of 85 with no blatant signs of brain damage. The tester blindly stands on the results proclaiming that the client is a borderline mental retardate.

This tester is demonstrating no commonsense and actually little "sense." Such results would obviously point to some pressure or

emotional difficulty that has depressed the client's intellectual interests, energy, and desire to intellectually perform.

A strong element of commonsense is one therapeutic trait which hopefully will be intertwined into all of the beginning therapist's work.

The next three characteristics which we present are not outlined to promote non-directive therapy. Rather, they seem to be good qualities to strive for regardless of therapeutic approach. Truax and Carkhuff (1967), in reviewing the literature dealing with therapists, found that three characteristics of effective counselors seem to emerge:

(1) Genuineness - an effective therapist is integrated, nondefensive, and authentic or genuine in his therapeutic encounters.

(2) Nonpossessive Warmth - an effective therapist can provide a non-threatening, safe, trusting or secure atmosphere by his acceptance, unconditional positive regard, love, or nonpossessive warmth for the client.

(3) Accurate Empathy - an effective therapist is able to "be with," "grasp the meaning of," or accurately and empathically understand the client on a moment-by-moment basis.

These three characteristics have been labeled many things by many different theorists, but they all add up to three very important therapeutic ingredients.

Good communication skills.

The effective therapist can also communicate effectively both verbally and non-verbally. In order to properly verbalize with a client, the "good" therapist must be an active listener. He essentially pays attention to the client's verbalization; he knows what the client is talking about. If the client expresses a statement which is confusing, he asks for clarification. A good example of the need for such action on the therapist's part is reflected in the following case:

> The people of the Applachian region of Kentucky have some rather unusual expressions which they use everyday. One foreign to this environment can very easily misunderstand the Appalachian's conversation. A psychiatrist, who was working in Eastern Kentucky and who had little interest or compassion for the Appalachians was evaluating one of the local men. The psychiatrist asked the gentleman what he did for a living, and the Appalachian responded, "I gin-around." The psychiatrist indicated on his report that the client was an alcoholic. The definition of "gin-around" is to work odd jobs.

This example obviously shows a need for more active listening on that psychiatrist's part. In addition, the counselor needs to communicate in understandable terms. Therapists encounter clients with varying degrees of education and intelligence, and these characteristics must be recognized. With some clients, you will need to speak in very simplistic terms avoiding any type of intellectualizing.

Even with intelligent clients, the therapist should avoid

"showing off" his great knowledge to the client by intellectualizing. The leaders in the field of Transactional Analysis have particularly stressed this point. Dr. Thomas Harris in the book I'm OK - You're OK (1969) states that psychiatry must develop a "public" language, decontaminated of technical jargon and suited to the discussion of universal problems of our society. He further states that vague meanings and complicated theories have inhibited more than helped the treatment process. His belief is nicely illustrated by this passage penned by Herman Melville, "a man of true science uses but few hard words, and those only when none other will answer his purpose; whereas the smatterer in science. . . thinks that by mouthing hard words he understands hard things."

Another reason to avoid jargon is that such information might be easily misconstrued by the client. For instance, a client describes some feelings to you, and you label the feelings as being "a little paranoid." The client goes home remembering only the word paranoid and begins searching his books for information dealing with paranoia. The client then becomes quite upset believing himself to be pararoid, and he sees no reason to live any longer. Therefore, he makes an attempt to commit suicide. Drastic problems can arise from the nonchalant use of jargon and labels, the beginning therapist must realize the potential problems which might arise when jargon is indiscriminately used.

A final quality of the therapist with good verbal skills is the effective use of verbal reinforcers. The "good" therapist is an active listener so he exudes a number of verbal and non-verbal characteristics which encourage communication. The therapist needs to reinforce andencourage the client's conversation. For many clients, their therapeutic experiences with you will be their first, and in many cases, clients will be anxious and not verbose. Therefore, for these types of clients reinforcement is necessary. Such statements as, "yes," "uh-huh," "good," etc., can be quite reinforcing. Asking questions and clarifying statements can also demonstrate to the client that his verbalizations are important and that you want to hear what he is saying.

Closely tied to verbal skills is the need also for non-verbal skills. If you are a normally active listener, then reinforcing non-verbal acts are probably already part of your repertoire of attending behaviors. However, we will review some non-verbal behaviors which need to be used by therapists. Always attempt to demonstrate to the client that you are interested in him and his problem by maintaining a relaxed but attentive posture. Coupled with an attentive posture should be a reasonable amount of eye contact. We do not imply that you should "snake-eye" your client, just that you should spend some time looking at him. This is recommended not only to demonstrate interest, but it will also allow you to better evaluate your client by picking up his physical reactions and mannerisms. Believe it or not, some psychologists can spend two hours testing a client and after the client leaves tell you nothing about his physical appearance or reactions.

Other methods of communicating non-verbally include facial

and head responses. Smiling, raising your eyebrows, changing your facial expressions, and shaking or nodding the head can all be effective methods of communicating non-verbally. These allow the client to know that you understand what he is saying and that you want to help. Finally, one can also communicate quite effectively by touching the client. Shaking hands or a pat on the shoulder can go a long way with some clients by reassuring them of their personal value. However, the act of touching cannot be used with all clients; some client might infer seduction on the therapist's part. An example of the possible negative effects of inappropriately timed touching is illustrated by the following case:

> A very dependent, young woman who was suffering from feelings of inferiority and inadequacy was seeing a young, attractive, male therapist. During one session, the client became very upset and began crying. The therapist attempted to console her by holding her in his arms. This innocent act was taken by the client as an act of seduction. The client began to believe that the therapist loved her and that she loved the therapist. The client-therapist relationship totally disintegrated, and other problems centering around this episode resulted.

Non-verbal communication can definitely enhance your therapeutic interaction if it is used in a natural manner, appropriately, and effectively -- not mechanically.

Awareness of the client-population;s "life style."

If the therapist is to be effective with clients drawn from a particular community, then that therapist must be aware of the idiosyncracies, mores, and "life styles" of the community. The inhabitants of New York City and Harlan, Kentucky are obviously worlds apart in their thought processes and behaviors. You must know what the law will allow in the community where you are practicing. If you want clients to respond to you in a positive manner or if you want referral sources to seek you out, you may need to modify your appearance or behavior. A long-haired, bearded psychologist might be quite successful in Los Angeles, but this psychologist would probable find success to be a rocky road in Hyden, Kentucky, in the core of Appalachia. The authors attended a convention where therapists were discussing their work. One hirsute, young psychologist working in Western Kentucky stated that the local people where he practiced did not like his long hair and beard, and that he had difficulties with many clients because of his appearance. This psychologist proclaimed that, "the people will just have to adjust to my looks." This statement seems to us to be quite unintelligent and unresponsive to the needs of the community. Obviously, this counselor has no business working at the clinic where he is employed for he expects a community to change to meet his needs.

Also, one needs to be well acquainted with population characteristics in order to properly carry on therapy. Some therapeutic procedures or suggestions will just not sit well with clients from certain communities. Encouraging parents to use the "no-lose method" with their children (Gordon, 1970) or a family council (Dreikurs, Gould, and Corsini, 1974) may be a difficult proposi-

tion in some communities. Some parents see their power as absolute and may be totally opposed to such a recommendation. Some communities support the concept of the all-powerful parents, and such suggestions, which are so diametrically opposed to community feelings, should probably be preceded by careful guidance and education.

Continuing education and growth.

The "good" therapist should always be learning, growing, and developing. We believe that when a counselor claims to have all the answers, then that counselor is in trouble professionally. Therapists should continue reading and studying, asking for advice and criticism, and trying new and different techniques. Attend as many meetings, workshops, and conferences that you can, and never become complacent with the therapeutic tools that you have. Always strive to improve, grow, and expand your capabilities.

Flexibility.

While continued growth through education is important, flexibility in recognizing one's own personal strengths and weaknesses is another characteristic of a "good" therapist. Once again, you are a fallible human being, and you do not and will not have all the answers -- recognize this and accept it! Sometimes you will need to seek help for your client through avenues other than yourself. Also, we believe that therapists should be flexible enough or therapeutically eclectic enough to meet the individual needs of each client.

> A college student was undergoing therapy with a counselor at the university's counseling center. One beautiful, spring day the student asked the therapist if they could hold their session outside. The therapist got very defensive and began criticizing the student for making such a request. Following this episode, the student reported that he lost respect for the counselor and that the productivity of their therapy sessions declined.

This therapist-client relationship was destroyed by inflexibility.

Be conscious of the role that you are presenting to the client.

Many clients view their therapists as being "normal," human beings who always behave in an appropriate manner. Often clients will model their behavior after therapists. In essence, the client may believe that by identifying with "normal" behavior he becomes "normal." Identifications with the therapist are easily observed. The client may dress like him, adopt his manner of speech, walking, and posture, or take over one of his characteristic gestures (Colby, 1951).

Some identifications on the client's part can be helpful, but we do not wish to imply that an over-identification should be encouraged for the client should be cultivating his own unique qualities. We do want to make you aware of the fact that such identification does occur. Therefore, you need to be somewhat cautious in your behavior. If a secretary accidentally interrupts your therapy session, would it be wise to yell at her and "put her down" in front of a client who is modeling your behavior? He might leave the session believing that one should put people in their place. Be careful, you will affect your client in many ways!

Using self-disclosure.

This is a troublesome area to deal with for it is difficult to determine what is enough and what constitutes too much self-disclosure. We believe that well-timed, self-disclosure can definitely enhance a therapeutic relationship. The purposes of self-disclosure should be to allow the patient to see that 1) you are human; 2) you can relate with his problem; 3) his difficulty is not unique, and 4) others have solved similar problems. An example of this procedure might be:

> A gentleman comes to you believing that he is the only person in the world who hates his job. He is quite depressed and feels trapped. You state that this is a very common problem, that this situation had even touched your life, and that is why you are working in your present position. You then go on to deal with your client's present situation and the possible alternatives he may choose.

Many therapists use self-disclosure effectively, but many others abuse the practice. The process of self-disclosure should act as a catalyst or stimulus, but sometimes the process is harmful to the therapeutic relationship. Some therapists use their clients as therapists. These therapists tell their clients all about themselves, their problems, and their solutions. In some cases, this practice may work, but in other cases, it may be difficult to determine who is the client. Keep in mind, the client is seeking help from you, the therapist. If you as a therapist need psychological counseling, then you should probably seek professional advice not the assistance of a client.

Resists countertransference.

The term "countertransference" stems from psychoanalysis. However, we choose to define countertransference as, "the tendency for the therapist to respond to a client in a biased manner because the client reminds the therapist of some important figure in his life." Whenever a client reminds you of someone in your life, and you begin filling in gaps in his story with speculative, unfounded data or responding in an emotional manner to his actions or verbalizations, then you need to reevaluate your approach with this client. If one feels unfounded anger toward a particular client or an irrational degree of empathy or concern, then that therapist may need to consider referring the client to another professional. If you cannot maintain some detachment from your client, your therapeutic effectiveness most probably will be adversely affected.

Objectivity and detachment.

We do not imply that a therapist should not be concerned with his clients' welfare, only that he should maintain a certain degree of objectivity and detachment. Without such objectivity or detachment, a therapist may severely stifle his effectiveness possibly resulting in a reluctance to doubt, question, challenge, or even confront his client. Remember, the client makes counseling work, and you, as a therapist, can only do so much. Many therapists are so afraid of failure that they assume personal responsibility for every unsuccessful case. A lack of success should not be considered a personal defeat. Some clients will never improve, but others may need to be referred to other professionals or other

agencies.

This brings up another area of concern for many therapists--referral. Once again, some therapists believe that if they refer clients to other professionals, their colleagues will think them to be poorly trained or equipped psychotherapists. This could not be further from the truth. The "good" therapist is concerned only with the best interests of his client. Thus, if referral is warranted, then he refers the client to an appropriate source. There are numerous reasons for referral such as (1) the client is openly hostile toward you, (2) there seems to be a definite personality clash, (3) the client is either a close friend or relative, (4) your political and religious beliefs are offensive to the client, (5) you have absolutely no expertise in the problem area, or (6) your therapy has reached a stalemate. You should be alert to the possibility of referral and if treatment will probably move more efficiently via another source, then consider a therapeutic referral.

A lack of success with some clients can often frustrate the novice therapist, and he may tend to blame himself and to bring his frustrations home. The authors hope that you will attempt to leave your work problems at work. Enjoy your time away from your office. You cannot solve your clients' problems by worrying yourself and your family. Clients generally have developed maladaptive behavior by practicing maladaptive behavior for years. Emotional problems are not overcome overnight. You can only do your best, and your client must do the rest. You will probably enhance your therapeutic effectiveness if you can generally divorce yourself from work and enjoy your leisure time.

Is a Particular Theoretical Viewpoint Mandatory?

We support theoretical eclecticism, but we do not imply an unbridled type of eclecticism. Raimy (1950) stated that psychotherapy is an undefined technique applied to unspecified problems with unpredictable outcome. For this technique, he recommended rigorous training. This type of unscientific eclecticism is not what we support.

Maultsby (1968a, and 1968b) strongly criticizes the concept of therapeutic eclecticism and states that therapeutic competence is probably more related to the use of proven techniques based on well understood, scientifically valid theory. However, Dr. Maultsby's argument is somewhat in question in that he firmly believes that his system of psychotherapy (Rational Behavior Therapy) is the proper approach for all problems. Therefore, he would hardly recommend a substitute therapy.

We do not believe that all clients are that easily "pigeonholed." All clients are not suitable for Rational Behavior Therapy just as all clients are not suitable for hypnotherapy. We believe that an eclectic approach is a good approach if one has some degree of expertise in the methods which he uses. The therapist who illogically and haphazardly applies a therapeutic technique is not reflecting our viewpoint. If one is going to utillize a method of therapy, then that therapist should have some training and study

in the area. We firmly believe that each client is a unique individual and that your therapeutic procedure can be tailored to fit the client. This type of flexibility is a must for those employed in a community mental health center. We believe that the therapist who can appropriately evaluate his client's needs and efficiently apply a unique and effective therapeutic technique is a very competent counselor. Client-centered counseling definitely will not work in all situations. The non-directive therapist might be flabbergasted if his techniques do not work with a particular client. An example of this situation might be a counselor attempting to use client-centered therapy with a severely retarded adult who is also a behavior problem. Where does he go from there? The therapist could refer the client to another counselor skilled in behavior modification. We believe that the full-functioning therapist should and must be well-versed in a variety of intervention techniques.

Summary

This chapter has looked at the therapist from many angles 1) who is he, 2) what is he, and 3) why did he enter the field of counseling? Additionally, the characteristics which many "good" therapists possess were reviewed, and a discussion of the constructive and destructive effects of counseling were covered. And finally, an argument in favor of technical eclecticism was presented. Many years ago a very wise gentleman neatly summarized the characteristics of a "good" therapist, and these recommendations still have relevance for therapists today. In his recommendations for those who treat the mind, Plato wisely included knowledge, benevolence, and boldness (Colby, 1951).

CHAPTER IV

The Therapeutic Environment

The therapeutic environment is much more than simply the location of where therapy happens. It does, of course, include the location of therapy, but it also encompasses the mood and the client's and therapist's expectations. Let us first attempt to deal with the most direct and understandable condition of the therapeutic environment, the location of therapy.

The first therapy location that comes to mind is the tradition private office. The private office is the traditional and most used location because it is very well adapted for what therapists do best; sit, listen, and talk to the individual who is in crisis. Although this is a very convenient place to do therapy, we contend that therapy need not be limited to this situation. However, in the private office much can be gained in the therapeutic sense. Privacy fosters the exploration of problems leading to confidence in the therapist and the secureness of confidentiality.

Some therapists firmly believe that the trappings of the office (the diplomas on the wall, the plush chairs, the big desk) have much to do with the confidence the client bestows upon the therapist. In other words, the client may feel that here is a man who has "made it" and his office reflects his success. Therefore, if he is successful with others, he can be successful with me. However, many people believe that an impressive office may take away from the humaneness of the situation and give the client the impression that he is not only in a therapist's office but also in the "hallways of the Kingdom of God." This feeling on the part of the client in the long run may do little to affect change once he discovers that he is not talking to God but rather to another human being who happens to have a beautiful office.

In some instances, the therapist may not wish to see clients with certain types of problems outside the confines of a private office. Other types of problems, however, may actually require therapy outside the office. An example of this might be a desensitization procedure to overcome a phobia such as a fear of flying. Perhaps, the best test of whether a location has any bearing whatever on a therapeutic outcome is whether or not people are actually helped in that particular location. Ultimately the benefits of therapy do not depend on location but rather result from the interaction which takes place between two human beings.

Much therapeutic work takes place in the institution in our society. These institutions often foster an institutionalized type of client who may feel not only constricted when he enters the therapist's office but indeed may even feel himself a prisoner. The feeling of being a prisoner can certainly be detrimental to a client's willingness to work on his problems. In fact the therapist may even be viewed by such clients as jailers rather than helpers. Often times therapists who work in institutions utilize behavioristic treatment modalities. In such situations, such therapists are directly involved in programming and designing treatment plans for clients. Frequently, behavioristic therapists will

leave their office to implement their behavioral plans. But on the other hand, more traditional, institutional-based therapists would utilize their private offices and possibly extend their one-to-one or group processes to the wards and/or cottages.

The mental health practitioner who works for a community mental health agency may often find himself in a situation where he does not have a choice of office but rather has a variety of possible work locations. This often leads to complications arising from difficulties with space, sound insulation, and possible intrusions. Many work locations in the community are ill-equipped to provide the client with a minimal amount of comfort or a reasonable expectation of confidentiality. On the other hand, there are many agencies which provide their therapists with excellent therapeutic environments. Some community agencies will offer their best work locations to the therapist, but, these locations may often prove to be quite unusual. For instance, working in a school cafeteria while people are setting-up for lunch or working in the corner of a busy emergency room of a hospital are not ideal but may not be unusual work locations. In some instances, the therapist may be more worried about the location than the client. While not recommended as a rule, these unusual therapy settings may be adequate settings for therapeutic gains.

There are many unconventional locations for therapeutic encounters, such as: a pool hall, a basketball court, riding in a car, walking in a park, home visits, hospital rooms, or even jail cells. Flexibility on the therapist's part in choosing a therapy location may just be the catalyst needed for continued growth in the therapist-client relationship. However, there is often the risk that a particular client might feel embarrassed to be seen with the therapist in many locations. In such cases, effective communications with the client should occur before the actual change of therapy location. Moving out of an office environment can be a risk and we strongly recommend that you consider the needs of the client before challenging him in a different location. However, we also believe that it can be a creative experience of breaking routine to make therapy more exciting and effective. True, you sacrifice some of the traditional trappings when leaving your office, but you may gain more trust and rapport and better help your client.

We feel that insight and a new perspective on how a client behaves is often gained in seeing him in a different environment. The beliefs which you hold regarding your client may be radically modified after you view him interacting with his environment. Leaving the confines of the office may serve to reinforce and validate the perceptions and expectations of both the therapist and the client regarding their roles and feelings about each other.

Moving to a different environment gives the therapist a chance to be an effective model for the client. The therapist who speaks of assertiveness training in the office and then displays it in the "real world" is being doubly effective. In essence, the therapist in the presence of his client should practice what he preaches. Thirdly, the authors feel that with some therapies a change of therapeutic location is not only desireable but necessary. This is most clearly seen in the process of systematic desensitization.

For example, work with a client in an office setting and preparing him to conquer a phobia may be a preliminary step to his actually conquering the phobia. But until he has actually dealt with the anxiety-provoking object or situation, he has not completed the desensitizing process. For instance, a man may have a fear of riding a bus. This fear can be worked with and the phobia can be partially desensitized in the office. But until necessary steps such as: 1) going with the person to a bus stop, 2) seeing the bus, 3) actually stepping on the bus with him, and 4) riding with him are experienced, then indeed a therapeutic encounter has not been completed. We firmly believe that reality should go hand-in-hand with theory. Therefore, the willingness of the therapist to transcend his office may be all important with certain types of therapies.

Where does therapy start? This is a very difficult question to answer because as a therapist you will often not be aware of where therapy actually starts for certain clients. For some people, therapy may begin with the initial phone call for an appointment. It may begin in their conversation with your appointment secretary or with your receptionist (that is why a secretary or a receptionist with a pleasing personality and a willingness to take a little time to listen to clients is a much treasured asset). Therapy can also start in the waiting room. Once again, a good secretary can set the tone. On the other hand, the secretary not attuned to human needs could set up a negative attitude in the client, thus encouraging him to develop wrong attitudes about the therapist or the agency.

Professional courtesy should demand that you see the client at the appointed time. You should not refuse your client if he is late five minutes, nor make the client wait because you are busily engaging someone in a trivial conversation. There are many discussions in the literature of what to do if the client is late. Some professionals believe that certain personality types use the "waiting game" to make the therapist angry with them and thus fulfill self-punishing desires. There is also the passive-aggressive type who uses this type of technique to instill anger and guilt in other people. This problem should be worked out in therapy and not become a "game" engaged in by therapist and client.

The initial meeting can be very important to the nurturance of a good therapeutic relationship. We feel that respect and courtesy should be shown to the client at all times. For example, it would seem absurd for a young therapist to address an elderly client in anything but a respectful manner. Decency and common courtesies should be followed in a therapy situation.

There are many different opinions as to how the initial contact between the therapist and client should be made. Many people feel that the "yellow brick road" approach should be used. That is, the mental health worker leads the client gleefully to the "wizard or the demi-God" who is expected to cure all their ills. This seems not only to project an aura of superiority, but basically impresses on the client that he is an inferior being. We feel that a client should be met "first-hand" in the waiting room. Not only is this a common courtesy, but it is also symbolic of the helping process.

Other friendly symbolisms in meeting the person for the first time might be a firm handshake, eye contact of the type that expresses interest, or offering a cup of coffee. However, this process can be carried too far; be friendly and interested but there is no need to patronize your client. Meeting the client's needs may also mean allowing him to do things for himself.

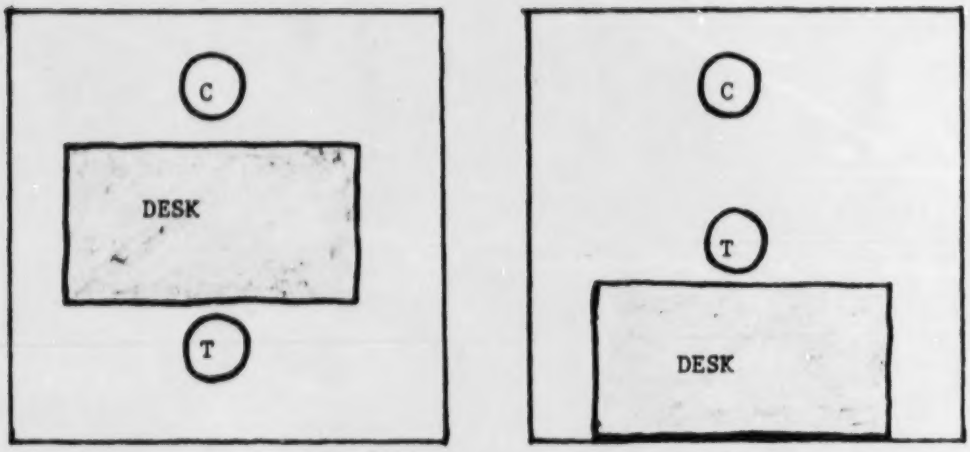
We now come to the topic of what types of furnishings should be used if you are ensconced in an office. The authors tend to feel that props or absurd trappings may appeal to a minority of clients or may promote some type of identification or instant rapport with but a small number. Tasteful decorations seem to be the best approach. We do not feel that charts of the human brain, skulls, or offensive posters are necessarily conducive to therapy. They may tend to take away from the basic fact that the person is there for help and not for an art show. The arrangement of furniture can also be an important therapeutic tool. One does not often see articles of furniture as therapeutic, but once you begin to place the furniture in certain positions, then there can be a nonverbal massage given to the client. Where the therapist and client sit, can be important. Does the client sit in a small chair across the desk from the therapist who has a large plush chair looking down upon the client? Or are the therapist and client sitting face to face in similar chairs as equals? Not only should the seating be comfortable, but also should provide for equality.

Office furniture arrangements are often not given much conscious thought. The novice therapist might consider why he is placing his desk and chairs in certain arrangements. Furniture arrangements denote two kinds of social information: 1) information about the occupant and 2) information about how the occupant would like others to behave when in his office (Jolner 1971). The relationship between therapists and clients may very well hinge upon placement of desks and chairs. Consider the office arrangement in Figure 2. Arrangement A implies a sense of distance between client and therapist, perhaps a lack of openness on the therapist's part. Now Arrangement B seems to indicate a complete openness on the therapist's part; whereas Arrangement C might denote a modified state of openness. Beginning and experienced therapists should arrange their office furniture in ways which best suit them, but one might consider the possibility that Arrangement B and C could promote more of a sense of cooperation than Arrangement A

A sound-proofed office is conducive to confidentiality and the need for confidentiality cannot be overstressed as it provides the basis for a trusting relationship. There is an old mental health saying that is worth remembering regarding confidentiality of data; it goes this way:

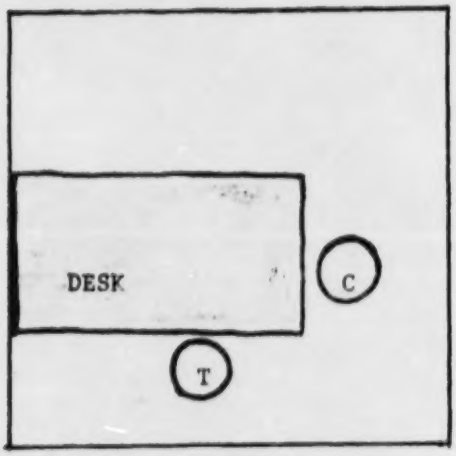
What you see here,
What you say here,
When you leave here,
Let it stay here.

The type of lighting used in your office or the use of background music are a matter of personal taste. Some clients may not prefer subdued lighting or background music, and your office conditions might be discussed with clients during your initial encounter.



Arrangement A

Arrangement B



T = Therapist
C = Client

Arrangement C

Figure 2: Office furniture arrangements

Another important factor pertaining to your office is that external disturbances should be kept to a minimun. Your therapy session should not generally be interrupted. If they do occur, they should be handled with tact. The appropriate handling of a disturbance can also assist the client in that the therapist is "role modeling" effective behavior. To prevent disturbances at critical moments, take necessary precautions. Tell your secretary that you are not to be disturbed, hang a sign on your door, institute an effective scheduling system for appointments, or have the telephone company attach a "ring, cut-off switch" on your telephone.

Some therapeutic environments are specialized, in that, devices or special therapeutic techniques may be used. The norm, as viewed by most clients, would probably be one-to-one therapy (one client and one therapist). Any deviation from this would be foreign or unique to many clients. Some deviations might be: 1) the use of two therapists; 2) therapy rooms with two-way mirrors; 3) tape recorders; 4) a television camera for videotaping; 5) hypnosis; 6) group therapy; 7) audio-visual materials; 8) written homework; or 9) bio-feedback equipment. Not all clients will take to these therapeutic deviations right away. The use of devices or special techniques should be discussed with clients in advance, and a period of preparation and guidance is necessary to make them aware of what you are doing.

Summary

Some who read this chapter would state that our ideas regarding the therapeutic environment are too liberal. Others might find them rather conservative. We believe that a position of flexibility is necessary to be effective therapeutically. The primary reason for environmental conditions or modifications should rest on the unique needs and personality of each individual client as ascertained by the therapist. Some clients will reject anything short of their personal concepts of what a therapist should be, or how he should dress, perform, act, etc. and discontinue therapy for such trivial reasons.

At the beginning of this chapter, we mentioned that the therapeutic environment not only included the location and physical space for therapy, but also we mentioned the fact that it includes the mood and the client's and therapist's expectations. This mood or atmosphere of the therapeutic environment is really intertwined with the physical environment. One can project the mood of therapy by the situation one is in, and the therapist can often manipulate the mood, success, or failure of a therapeutic encounter by manipulating the therapeutic environment. The beginning therapist, in particular, must be aware of the interaction between the therapeutic environment and the success or failure of therapy.

CHAPTER V

Beginning Stages of Therapy

There are numerous reasons for individuals to seek the services of a therapist. First of all, the person may be experiencing psychological problems or distress. The individual could be free of psychological stress and interested in direction or guidance. Thirdly, some clients may be seeking information only. While others may desire therapy as a growth experience. Some people will seek out therapists for an opinion as to whether or not they really do have a problem. Others will want to use the therapist as a "sounding block" to unload a problem or in other words, the experience will serve as a time of catharsis. And finally, often individuals will consult with therapists for advice or guidance in dealing with a problem situation that they may or may not be connected with.

As you can easily see, there are many different reasons and situations which promote a therapist-client relationship. However, we will focus attention on the therapeutic encounter involving individual therapy. Therapy is often viewed as a three-pronged affair involving: 1) exploration, 2) understanding, and 3) action, but these processes are usually continuous occurring again-and-again during a therapeutic episode. Clients often speak of a singular problem, but often one sees a number of problems in addition to the one defined by the client. Therefore, each problem situation will need 1) exploration, 2) understanding, and 3) action. These processes have application for both the therapist and the client because the therapist also needs to explore and understand in order to stimulate effective action. The first encounter between client and therapist is a most important time, for this is a time of evaluation regarding the client's suitability for your brand of therapy. In fact, just because some referral source suggests therapeutic treatment for an individual, the therapist should not accept this opinion as "gospel." You as a trained therapist may believe that the client could be best served by referral to another professional, group, or agency.

The first session with a client is also important because therapy can and often will begin from the first encounter. If a therapeutic relationship is established, then the warm, non-judgemental atmosphere of the therapist's office can promote growth in the client. The therapist should strive during the first few sessions to establish good rapport in order that the client might feel at ease and feel less anxious about talking with a counselor. The establishment of good rapport also encourages the client to explore and discuss a wide range of material of concern to him. Also, the first few encounters should impress the client as times where what he has to say is very important. Therapists must be active listeners and this process shows the client that someone cares and that someone wants to listen to what he is saying.

The first few sessions with clients may be utilized strictly for evaluation, history-taking, and as a time for familiarization. Don't rush into a situation until you know where you are and where you should be heading therapeutically. Be an observer and effect-

ive questioner (not the third degree, though) and attempt to fully understand the client's perceived situation. An effective therapist should be warm, friendly, and present an empathic attitude, but he must also be objective and emotionally detached. In addition, while evaluating clients, one must look beyond the face value of the language used, in other words, read between the lines. If a client is discussing how t tally distraught he is and he mainfests a very calm, "happy-go-lucky" appearance, then one might question the validity of his statements. The therapist should also observe such non-verbal signals as: body language, the volume of his speech, the intensity of his communication, and other signals such as crying and weeping.

The initial contact also is an important time for developing operational definitions. The client should be encouraged to precisely define his problems and clarify the specifics related to his problems. In addition, these first few sessions can be a time to establish roles and goals for the client and the therapist. The therapist implies that he does not magically work wonders, rather the client must personally work hard to improve and alleviate problems. Also these first sessions enable the therapist, who might be therapeutically eclectic, to match the client with the most useful or appropriate method of treatment.

Some therapists use unorthodox therapeutic methods, instruments, or gadgets, and these unusual devices or methods should be introduced and explained to the client early in your relationship. Why? There are many reasons: 1) this procedure will help reduce fright and anxiety in the client; 2) you initially establish an air of genuineness and honesty which will probably promote feelings of confidence; and 3) the client may have preconceived ideas about how therapy should be done, and an explanation may be necessary to modify these thoughts. When we mention unorthodox methods or instruments, we include the following: 1) hypnosis, 2) biofeedback instruments, 3) videotape cameras, 4) tape recorders, 5) the use of family trees, or 6) the use of relaxation training. The list certainly could go on, and these are just a few examples of methods or devices which might seem strange to a client. Whenever something out of the ordinary is considered as a therapeutic tool, the therapist certainly must first consider the "life style" of his community and the idiosyncracies of his client. For example, one would not generally expect "nude therapy" to be a popular methodology in an Amish community.

Other Ways To Better Understand Your Client

In some cases, simple or intensive interviewing does not reveal enough data about your client to enable you to really understand his unique situation. Therefore, understanding is often improved by utilizing other methods. For instance, to better explore a client's capabilities and dynamics, psychological testing may be warranted. In other cases, the therapist may bring in family members or persons close to the situation to further investigate, support, or negate the client's reports. Additionally, some therapists may wish to communicate with other professionals

to get advice or a different viewpoint, or one might contact other agencies (within legal and ethical boundaries) which have dealt with your client previously. Finially, the therapist might consider observing his client in different environments to see how he responds in a variety of settings. In many cases, this procedure would be with the client's knowledge, but sometimes some unplanned or essentially clandestineobservation might be necessary. The authors remember a situation involving a gentleman who feigned leg and back injuries to receive insurance compensation. After he thoroughly fooled the medical community, he was observed in a restaurant to be quite spry and void of injury.

Establishing Realistic Expectations for Therapy

Remember always that the client makes therapy work; therefore, the client must be an active participant in the therapeutic process. Colby (1951) states that "the beginning psychotherapist should beware of trying to convince the patient that he needs therapy. It is a mistake, often disastrous one, to break the patient down by showing him how badly off he is and thus frighten him into therapy. Also unwise is the attempt to lure the patient into treatment by promising him he will feel much better or get along with people more easily." Additionally, the therapist should not promise any passive or magical cures. Therapy is hard work for both the client and the therapist and cures do not come through passiveness or magic.

Therapy is a very unique human experience, and if handled properly in the initial stages, can be a tremendous growth experience.

> The non-judgemental attitude and atmosphere of the therapy session allows the client to freely discuss, study and understand something in him without necessarily condemning it. Once an attitude of his is worked through in this manner, he is free to choose then whether he wants to change it or keep it. (Colby 1951, p. 68)

This process of course leads us into the middle and later stages of therapy.

The Middle Stages of Therapy

Assuming that your counseling sessions run for more than one or two sessions, you will have a middle stage. If the counseling runs for only one session, one might define this type of encounter as crisis intervention. A question often raised by therapists is, "How often should you meet with a client." There are really no hard and fast rules to determine the length of counseling; however, there are some informal guidelines one might follow. One guideline is meet as often as seems necessary, depending on the severity and the type of problem that the client presents. Initially, the relationship may require that the therapist and the client get together very often, perhaps as frequently as two or three times per week. However, one should try to maintain some control over the frequency of the sessions and their longevity because the client may tend to become overly dependent on the therapist. The client

might start turning to you for advice regarding the most minute problem. You may, of course, become frustrated by this type of over-dependent client, but always realize that you have some control in the therapy and the client gains as much control al you permit.

The therapist might, through mutual agreement, allow the client to set the frequency of sessions and the length of the counseling sessions. This procedure of course, will depend on a number of factors including the availability of the therapist, the severity of the client's problems, and the client's therapeutic progress. The best approach is not to feel that there are some arbitrary guidelines which must be followed in a therapeutic encounter. Therapy should not be extended just to meet some arbitrary criteria.

Another question asked by novice therapists is, "How long should therapy sessions last?" The same rationale should be applied to this question as was applied to the previous query. The length of the session should be dependent upon the severity of the client's problem and the time needed to fruitfully discuss the problem. Initial sessions which usually involve a gathering of historical data may last 60 to 90 minutes or more. Generally, your sessions will shorten and may range during the middle stages of therapy from 30 to 60 minutes. The therapist, once again, should not be guided by some arbitrary conditions. Some clients will need more time than others. Also, some therapeutic techniques may not require an extensive amount of time, for example, a behavior modification procedure during its middle stages may mean that the client merely checks in with the therapist for 20 to 30 minutes.

In a discussion dealing with the middle stages of therapy, we must describe two important situations which the beginning therapist must be prepared for or consider utilizing. These are confrontations and impasses. Regardless of the type of therapeutic technique used, the therapist may need to confront the client regarding the client's thought processes or behaviors. When we discuss confrontation we use the definition outlined in Beyond Counseling and Therapy by Robert Carkhuff and Bernard Berenson (1967):

> Direct confrontation is an act, not a reaction. It is initiated by the therapist based on his core understanding of the client. It brings the client into more direct contact with himself, his strengths and resources, as well as his self-destructive behavior. The purpose of confrontation is to reduce the ambiguity and incongruities in the client's experiencing and communication. In effect, it is a challenge to the client to become integrated; that is, at one with his own experience. It is directed at discrepancies within the client (his ideal versus real self); between what the client says and does (insight and action); and between illusion and reality (the therapist's experience of the client versus the client's expression of his experience of himself and the therapist). The therapeutic goal is nondestructive and emerging unity within the client. It implies a constructive attack upon an unhealthy confederation of mis-

> cellaneous illusions, fantasies, and life avoidance techniques in order to create a reintegration at a higher level of health. The strength and intensity of a confrontation may correspond with how dominant and central the emotional pattern is to the client's life style. The therapeutic risk will also depend upon the amount of disorganization both the therapist and client can handle.
>
> The quality of a confrontation, then, corresponds to the experiential shell, emotional integration, and intent of the therapist. It is a risk which the therapist takes out of deep commitment to the client in the recognition that the client's defenses are his enemy and do not allow him direct contact with himself; they interfere with nourishing contact with other men. In this sense, the therapist pits his health against the client's sickness while at the same time being a formidable ally of the client's health. The therapist is the enemy of the client's self-destructive tendencies.

Confrontation may be a crucial aspect of the middle stages of therapy, but if utilized, the therapist should consider the following factors: 1) Timing is all important. A word of caution is advised here as some therapists would jump right in with many confrontations early in a therapy session. This procedure may cause a loss of the client because of the anxiety provoked in these confrontations. It must be remembered that confrontation is an action, not a reaction, and should be a carefully thought out procedure. 2) Another important fact to remember is that if you are going to confront someone, a positive rapport should be built up before "slamming home" some aspect of their behavior that is disrupting for them. Certainly a build-up to confrontation is necessary through harmless demands for clarification, explanations, or justifications. 3) How much confrontation is good for the client? Again, as in many other aspects of therapy this is a highly individualized decision on the part of the therapist, but some guidelines can be brought forth. First, it is highly unlikely that a competent therapist would want to tear down the individual's belief system in one "fell swoop." The client may not like the approach or your interpretation, view them as attacks, possibly voluntarily terminate. A good rule of thumb then is to give only what you feel in your gut that the client can handle at that particular time. Destructive confrontations come from frustrated therapists and may alienate the client or influence self- destructive behavior on the client's part. On the very practical level, a client's reactions to appropriate confrontations or interpretations may seem frightening to some novice therapist. Experience will reveal that such methods often will stimulate action and may be what is needed in many therapy situations. One reaction that may be evoked is crying behavior. This behavior does not necessarily indicate sadness or instant insight. The client may be choked up, unable to deal with the emotional impact of your statement, and therefore may be incapacitated by it for a few moments. Strong agreement may be elicited by the client, or he may become angry, he may change the subject, become overly anxious, go into

an unduly long contemplation or reflection of your statement. The client may simply agree but this is not sufficient evidence that the confrontation is believed accurate. The client's reaction and later action will indicate the validity of your confrontation. All the above behavior shown by the client will need further interpretation and perhaps further confrontation as it applies to the nature of the confrontation itself. Lastly, and perhaps rather frustrating for many therapists, the client may simply ignore your confrontation and go right on with his verbalizations or the behavior that he was exhibiting. This of course is distracting to the therapist, but it is a situation which a good therapist must learn to handle.

Confronting can also be done in a less threatening way without a verbal interchange. The client may be instructed via the use of TV videotape or a movie which in some way directly or indirectly deals with the problem that the client is experiencing but yet as a spectator, he is somewhat removed form the emotional impact of it. Another device, of course, would be listening to a tape recording or a short story based upon the identical type of problem the client is experiencing. Another effective procedure that the authors have used in their own particular therapy encounters would be analogies combined with stories or jokes which often "bring home" very important points. Taking clients on field trips may also be utilized as a confrontation technique.

After seeing some of the behaviors that may be elicited, you may rightly ask yourself why is it necessary at times to precipitate a crisis or confrontation. The authors stress that this is frequently the only way to encourage growth on the part of the client. By this, we mean that some clients, in order to fully understand their problem, must be willing at times to explore the depths of the problem. This often, of course, leads to the outcropping of emotional feelings, some intense, that may bring pain to the client. This pain, of course, is not the end goal of the process of confrontation, but it frequently is a means to encourage the client to inspect his own feelings and to grow from a full realization of their importance. The process should be used carefully and thoughtfully.

Impasses frequently occur in the life cycle of the middle stages of therapy, in that, points are reached where there seems to be no growth or no resolution of problem areas. An impasse may be felt by either the client or the therapist. These impasses may result from a number of situations; however, they are not to be ignored and should be dealt with. An impass may develop from a frustrated therapist who projects an air of disinterest in the needs of his client. In this situation, it is important to focus on why you are functioning in this manner and attempt to determine if you are really interested in this particular person. If not, then you can readily see why an impasse would develop.

An impasse may also result from a client who is not moving forward, therapeutically. An example of this is the client who talks and talks about what needs to be done but never actually jumps into the action phase of his understanding. A discouraged client, one who is looking for a therapist to work magic for him,

may find out indeed that there are no magic shows in therapy. An impasse may also be due to transference, countertransference, or simply resistence.

There are many, many ways to deal with impasses. First of all, one might review what has happened and the possible causes of the impasse, and then discuss with the client what needs to be done. Also, one could encourage action on the part of the client. For some people, this is all the motivation that they will need to get themselves going, or you could actively assist a client. Assistance is frequently noticed in behavior modification procedures where the therapist actively assists the client in learning new behaviors. Another way to deal with the impasse is to take a break, to discontinue therapy for awhile. In much the same manner as taking a walk and looking away from the problems for awhile may give you a fresh outlook, this is the purpose of discontinuance and explain to the client what is happening. One does not inadvertently want to imply to the client that he cannot be helped. If the impasse seems to be permanent then, referral to another appropriate therapist or agency might be considered. Before this step is taken, the therapist might wish to redefine to the client what therapy is all about, in the hopes that new light can be shed on the nature of the impasse.

Relapses

Sometimes during the middle stages of therapy, therapists will observe that their clients have relapsed. Relapses occur when clients seemingly go back to behavior patterns that were in evidence during the early stages of therapy and are by their definition non-productive. Don't be afraid of the relapse occurrence; it is simply another situation that you must deal with and is sometimes indicative of a problem at a more basic level. The client may simply enjoy the participation with the therapist and if he gets well too quickly, this enjoyment will end. Relapses may occur with a passive-aggressive type, who is trying to frustrate the therapist. The fear of getting well also frightens some clients because "being well" requires changes in well learned behaviors. Another situation that occurs, probably closer to termination, is that the client will suddenly get "cold feet" at being set adrift in the "cruel world" by the therapist. The client may resume old behavior patterns and then say to the therapist, "Hey, look at me, I'm just as bad as I was, don't let go of me!"

There must also be a realization that some relapses have very little to do with the client/therapist relationship but are based on stressful happenings in the person's environment. This situation might occur after the death of a loved one or following some tragedy.

There are, of course, many and various ways to deal with relapses. The best guidelines that the authors believe can be presented are to use those therapeutic characteristics and qualities which allowed you to get to the point where the client could have a relapse in the first place. These qualities, of course, are supportiveness, interest, accurate empathy, genuineness and appropriate confrontation and explanation. Other approaches that behav-

ior modifiers, in particular, might use would include changing the reinforcers, the reinforcement schedule, etc. Another approach would be to change therapist. This is not an unusual occurance, it happens many times. When the therapist believes that because of personality conflicts or constant relapses, that the client would be receiving much more efficient help from another person, then referral should be made.

The middle stages of therapy might be called the "meat and potatoes" of therapy for this is where the action generally takes place. As part of the very nature of therapy, each individual confrontation, every impasse, relapse, or situational trauma must be dealt with effectively for growth to occur. The ideal situation, of course, would be one where exploration, understanding, and action take place in an unfettered manner, but the ideal situation never seems to take place in such a smooth and efficient manner. The therapist must realize that if he is afraid of precipitating crisis for the good of the client, then many areas which the client is reluctant to bring out, but would nevertheless be helpful to him, will never be dealt with. The middle stages can thus be viewed as the working grounds, the working environment of therapy.

Ending Therapy

Termination, or "the ending of therapy," can be a very simple or a highly complex procedure. Perhaps the most usable definition of termination is the one which is also the most parsimonious. Termination then is simply that awareness that the identified problem or problems have been dealt with, alleviated, or eliminated and it is simply time to stop. This, in most cases, is not a decision that is made by the therapist alone, but a decision that is made in agreement with the client. There are numerous situations and indications which will set the stage for termination of therapy and these will be mentioned in the following section headings.

When The Patient Wants To Stop

When the patient feels that he has reaped all the possible benefits that he can reap from therapy, he will begin to give certain indications that he is ready to move on. Some clients may feel that a cure has been effected, and they will express this feeling in so many words to the therapist. This can be defined only as a subjective feeling of the client that he has received some relief from the initial reason for which he came. This is always a positive situation and should be dealt with by the therapist in a very positive accepting manner, one which allows the client to feel some success in this venture in his life. The second situation by which the client may want to terminate is that he simply does not want to continue. There are many reasons for this, (as many reasons as there are clients). One of which is the client feels he has made no progress in therapy. Again, this is a subjective feeling and the client should be allowed to have this feeling and make this evaluation. There may indeed be reasons for termination because of a personality conflict between the

therapist and the client. This happens quite frequently, perhaps more frequently than therapists would care to admit, and it should be recognized as a very realistic situation. Once realized, an honest agreement should be made to either find another therapist or to explore the areas of the personality conflict. In any case, if the client is adamant that you are not the therapist for him, by all means respect his wishes and allow him the freedom of choice. Discrimination should be made here, however, between the client who is merely becoming resistant because of important therapeutic material that is being brought up and between the client who genuinely does not feel comfortable with his present therapist.

Another reason may be that some clients are of such a genre that they feel a particular displeasure with the therapeutic modality that the therapist is using. That is, a client may not be of a particular intellectual or emotional level to be involved with certain types of therapy. For example, the authors know of a particular situation when a client was subjected to various sessions on divorce therapy when a client was a devout Catholic. Needless to say, the client was very displeased with this particular therapeutic procedure and finally worked up enough courage to inform the therapist. A quite common reason for client termination is that they have found a substitute therapy. This frequently happens when a client goes to a physician and obtains some chemicals that will temporarily relieve feelings of depression, anxiety, etc. This is to be recognized as a very valuable form of therapy, and they may indeed drop out of therapy when they find this type of relief. If at all possible, a communication link between a physician prescribing drugs and the therapist would be helpful in providing for the needs of the client. The situation may also arise where you see a client who has been referred by an agency, particularly the courts. Frequently these client must attend a specified number of sessions and when their time is up, they may be anxious to leave therapy.

Other common situations which lead to termination are ones in which the client wants to continue but has to terminate because of financial reasons, movement from the area, a change in occupation, etc. If the client wants to continue whatever progress he has made in therapy, it becomes the responsibility of the therapist to recommend another agency or help the client with an appropriate referral to an agency with will either meet his financial needs, or will be in his new location. On rare instances, if one is seeing a child in therapy, the parents may withdraw permission which, of course, is their legal right to do. In conclusion, it is also possible that a variety of external forces or motivations will force discontinuance of therapy and this must be recognized as a therapeutic reality.

Since therapy is also a two-way street, there may be situations in which the therapist may wish to terminate proceedings. The therapist may simply feel that there is a lack of progress in a relationship and would like to refer the client to someone else, or there may be a personality conflict. In some cases the therapist may see a need for termination, i.e., the problem is

obviously solved, however the client would not want to stop. They seem to be enjoying the positive aspects of therapy and of course would like it to continue as long as possible. This, of course, is a time for judgment on the part of the therapist and a confrontation may be necessary to help the person move along in his lifestyle. The therapist may of course be leaving to a new job or a new location, and in this instance, it behooves the therapist to provide proper transfer to another therapist or to make some arrangements to see that the person is not stranded. Finally, a very good clinical usage is sometimes made of termination in that the therapist may use it as a learning situation for the client or as a way of dealing with the client's particular pathology.

Termination should not be "cold turkey." Some clients will need the gradual releasing process, and some will need a more abrupt firm reason for termination. For the client who needs a gradual desensitization to termination, you must realize many of them have built up a very dependent relationship with the therapist and they will need a gradual weaning process to allow them time to release themselves from these dependent feelings. Many times this type of client needs to be educated in the fact that termination is not a rejection process but a move toward progress. Indeed this must be a carefully planned encounter because the client may have had a long-term relationship with the therapist and now he needs to be attuned to a resurfacing of problems and anxieties that may result once the word "termination" is mentioned. This is commonly called "termination anxiety" and this is the reason that many clients of a dependent type need to be primed for a gradual withdrawal. If the therapist is leaving and therapy is not being ended for any clinical reason but merely because the therapist is leaving the area, this situation also may arouse "termination anxiety." Once again, this should be dealt with in a very realistic firm manner, and if possible, the client should be reassured that another therapist will become involved in his case. Many procedures can be used to condition the client to the fact that you will be leaving and one possible way to do this is to involve another therapist, his future therapist, in your sessions.

Many times it is clinically necessary to refer a client to a group process. Groups, are of course, beneficial in many ways to some clients, and if termination is for this reason, it should be explained in detail. That is, the therapist should explain exactly the reasons why he is sending the client to a group, how he hopes this will benefit him, and how he hopes that entry into the group will be a natural flow from individual therapy.

How To Terminate

Methodology of termination is, of course, an option for each therapist. However, we would like to state some of the more common methods for your consideration.

Verbal cues to the client are perhaps the most direct method of beginning the thermination process. Statements such as, "You're really doing much better now," "You may not have to see me as much

now," or "Boy, you're really learning how to handle your problems" are effective ways of initiating the termination process. Often in therapy at the time near termination, it is wise to tell those clients, who are particularly perceptive, that you feel you have done all you can for them. This type of client needs an open realistic discussion of the way his problems were, the way he sees himself now, and how he can plan for his own future.

Non-verbal cues, may occur long before a verbal statement is made. Suddenly the dialogue between the therapist and the client comes across as being between two equals rather than between therapist and client. Two other cues that may point to termination are the gradual spreading out of appointments and decreasing the length of the sessions. Spreading the appointments from one week to two weeks shows the client that there is no longer a need for such intensity in the relationship, and the unstated reason is that he is getting better. Decreasing the length of the session also says the some thing about the intensity of need and is also a positive statement about his progress. In some instances a carefully planned termination process is not necessary. The client himself will often let you know that he is ready to terminate, and this, of course, is something that the therapist must be ready to deal with at any moment. Finally, with some clients and some particular types of problems, a setting up of time limits, including the termination date, may eliminate the need for termination methodology or any drawn out process. This is in line with the contracting procedures now in vogue and which has considerable merit with particular types of problems.

One of the concerns of therapists all over is the perpetual client. This is the client who for reasons of dependency or whatever gains he may be receiving from therapy continues with his therapist as long as possible. Indeed, in some particular brands of therapy, client-therapist relationshops have been known to go on over ten years at a time. Some clients never seem to want to get better. Therefore, they choose to come to therapy for extended periods of time. For these particular types of clients we advocate a very intense approach, including confrontation or a contractual agreement. On the other hand, some clients can be seen for years on a maintenance schedule where they occasionally check in with the therapist to discuss their present situations. And then, of course, there is the client who is so accustomed to negative feelings that good just doesn't feel right. This client in a very masochistic way loves to feel downtrodden, depressed, etc. because he gets a maximum amount of attention for a minimal amount of effort. Finally, it should be noted that there is a difference between termination and accessibility. Termination deals with situations where problems have been alleviated and there is definite agreement between therapist and client that intervention is no longer necessary. Accessibility is defined as the therapist being available to the client after a long period of time for the client to check in to see if things are going the way he wants them to. The former denotes a planned ending to intervention and the latter denotes a maintenance type schedule. The client who contacts his therapist for help soon after termination has experienced a premature termination and goals that were thought to be accomplished

may not have been accomplished and need to be reevaluated.

In summary, then, we see that termination can be brought about for many different reasons. It may either be client initiated or therapist initiated, but the end goals are both the same. That is, both the client and the therapist agree that mutual objectives have been accomplished and there is no longer a need for this type of encounter. Termination is merely the ending of a process of helping. It must also be remembered that mutual goals are sometimes not attained but that the client has the right to discontinue therapy is he himself feels that his goals have been met. If a client quits coming of his own volition, the therapist should not take this as a personal offense. Termination again could be for a number of reasons, and if possible, one should follow up on such clients. They may give you clues to your particular service, and it may be a learning experience which may enhance your skills.

Dealing With Special Problems And Complications

Most therapists would like for every session with their clients to be a positively grand experience, but unfortunately into every therapist's life some rain must fall. Every therapy session will not be enjoyable or turn out the way you would like for them to. Aslo, every client that one encounters will not be pliable, interested, motivated, and pleasant. A therapist should always evaluate his procedures and constructively critique his effectiveness with clients, but just because you and a client do not function as a well-oiled maching is no reason to assume that you are not "good" or effective. Some therapy sessions could best be described as just plain "bad" where nothing seems to be accomplished. While other sessions are very positive, inspiring experiences which seem to be good for both the client and the therapist. Do not allow complications or crises experienced during therapy sessions get you down. Expect such occurrences to arise and use both positive sessions and negative experiences as periods of learning. Both of these experiences allow the therapist to gain further knowledge about himself and his clients.

The Client Who Quits Coming

The beginning therapist must realize that some clients will terminate treatment before treatment is completed. Some will terminate after one session. There are a number of possible reasons for termination, and the therapist should not assume that he is to blame. If possible, one should follow up on such clients and find out exactly what the problem might be. If there is a legitimate reason which relates to the therapist-client relationship, then in some cases the client might be invited back for one more session to explore the

problem. Referral to another agency or professional could be considered if the client does not wish to be involved with you as a therapist. However, in some cases no therapist, regardless of who he might be, could help some clients. Some clients will manifest these resistances:

A. All of the client's time and energy is spent resisting help or denying the need for treatment;
B. Others proclaim that all therapeutic advice or suggestions have no application to them, i.e., "I'm different, what you say doesn't apply to me!";
C. Some clients are expecting magical manipulation by their therapists, in that, the client sits back and watches while the therapist makes everything better; and
D. Others find getting better too much effort or disruptive; being "sick" is comfortable and familiar and they feel better "feeling bad."

Common Complications Encountered During Therapy Sessions

Silence: Some therapists get overconcerned about this situation. Every therapeutic relationship will experience some moments of silence, and this is nothing to be afraid of. Generally, the therapist does not need to intervene. Usually the client will feel uncomfortable and assume that he must make some comment. Why does silence occur? These are some common reasons:

A. Silence is used as a time of comtemplation;
B. A period of silence may be necessary for some clients to gain enough courage to make a statement or to discuss a particular problem; or
C. Excessive silence may indicate that the client is Especially anxious or tense.

When dealing with silence, let both common sense and non-verbal cues be your guides. One problem may be the rapport, and the therapist must concentrate on building a relationship of trust with the client. There are essentially four methods for dealing with episodes of excessive silence; they are 1) ask the client what he is thinking about, 2) ask him a question, 3) ask the client why he is silent, or 4) simply wait the individual out in a very receptive manner.

The Yes/No Syndrome: This particular problem situation arises during the initial stages of therapy when the therapist asks questions and the client answers with a short statement or with a "yes" or "no". The therapist obviously contributes to this problem. He must ask multifaceted questions which must be answered with more than a word or two. This procedure shapes the client into speaking broadly and voluntarily about himself and his problems.

The Excessive Talker: Some clients are determined to dominate the therapy relationship by doing all the talking and by not allowing the therapist to contribute. Adlerians (Mosak and Shulman, 1974) point to four possible reasons for excessive chatter:

1) the client does not want to experience therapy and it is basically a method of resistance;
2) the client wants to control the sessions;
3) the client does not want to hear the therapist and possibly be assisted or hear the truth about his behavior; or
4) the client talks about everything but the main problem and essentially the main problem is being avoided.

There are many ways to deal with the excessive talker, some are:

1) confront the client with his behavior and then explore the situation;
2) use selective reinforcement, only act interested when the client discusses a pertinent issue;
3) use a novel approach -- relaxation therapy or have the client write about his problems; or
4) make a contract, he can only talk about unimportant side issues during the first ten minutes of the session.

Crying: This is a problem situation which all therapists will encounter, and the therapist must attempt to respond appropriately when such behavior occurs. Definitely the therapist must analyze the crying behavior and determine whether it is manipulative or genuine. A genuine release of emotion through crying can be a very therapeutic experience, but manipulation through crying destroys the therapeutic relationship. How should one deal with a crying client? Do not be too indulgent. You are not required to pat the client on the shoulder or to hug the client. You should remain objective, offer a tissue, and wait until the client is ready to continue. Overindulgence may lead to a breakdown of the therapy-client relationship and may be misconstrued as romantic gestures. Also overindulgence by the therapist indicates easily to the client how the therapist might be manipulated. Manipulative crying can be handled in two ways: 1) confrontation regarding the situation or 2) ignoring the behavior both physically and verbally and responding only when the crying ceases.

Transferences and Countertransferences: We will loosely define these concepts as the situation occurring when someone reminds you of a significant person in your life and when you respond to this person in a manner in which you have or would like to respond to this significant person. The feelings arising from such situations can be of either a positive or negative nature and both can disrupt therapy. If a client is responding toward you in an inappropriate or hostile manner with little or no justification, then you might explore the possibility that he is responding to you in a biased manner. He might even make such comments as, "You're just like my brother" or "You're just like my uncle." Some client might view you in a positive light and cater to you, bring you gifts, or attempt to make you fill a role.

If exploration is not fruitful, then referral to another professional might be necessary. Likewise, some therapists experience countertransference and respond in a biased manner toward particular clients. The therapist may tend to pigeon-hole a client and engage in emotional speculations. Also, a dynamic approach to therapy may be dulled because of countertransference. Once again, if the therapist cannot work through this problem, then he should consider referral.

Hostile Clients: Clients often are hostile toward therapists because they are forced into treatment by schools, courts, agencies, parents, relatives, or institutions. These clients are not angry at you; you are merely a "scapegoat" for their frustrations. At times like these, you need an extra degree of understanding and empathy because you have an obligation to these clients also. Initially, the therapist should be concerned with building rapport and avoiding confrontation initially is a good practice. Confrontation will probably only add fuel to the fire, and one might consider the idea of being very non-directive and concentrate on reflection only. Later, after a good relationship is built, should one begin to probe and confront.

Personal Questions: Some clients will ask you personal and probing questions, and some of these might disturb you or put you on the defensive. If the client is not attempting to evade therapy, then one should answer as honestly as possible. In some cases a well-timed lie may be more beneficial though. You will probably encounter such questions as:

1) Do you think I'm crazy?
2) How old are you?
3) What's your training?
4) Are you married?
5) Have you ever helped anyone?
6) What are your political and religious beliefs?
7) Are you any good?
8) Have you helped anybody before or am I your first case?

The beginning therapist must realize that some clients are looking for any excuse to torpedo therapy. They can negate the value of therapy with a particular therapist because he is old, young, tall, short, democratic, republican, Baptist, atheist, etc. Some comments by clients may need to be answered in a confrontive manner, such as, "My political beliefs have nothing to do with this therapy session;" while others may require a well-thought-out reply to get back on track, such as, "I have helped many individuals help themselves, for each client is ultimately responsible for the success or failure of therapy."

Physically Aggressive Clients: Some therapists have experienced the wrath of physically aggressive clients who have either attacked them or their office furnishings. These kinds of situations are very rare, but they do occur. Certain clients who are immaturely impulsive, situationally upset, brain-damaged, or schizophrenic might suddenly feel a need to attack you, throw furnishings around, or throw something at you. One might consider having only a few desk items of potential danger between you and the client.

Aluminum or paper ashtrays might be considered when working with hostile or disoriented clients, or the therapist might consider having a fellow worker close-by in case of trouble.

When a client does become physically abusive, the therapist should attempt to calm him down or remove himself from the scene. If the therapist must defend himself, then he should defend himself enough to get out of the room. Remember that you personally cannot control all clients and their behavior. Therefore, in some cases, others such as professionals, the police, or ward attendants, may be needed to subdue some clients.

Whether or not the aggressive episode should be discussed in later sessions depends on the client; discussion of such episodes would be fruitless with some clients. Also, the same holds for damage done to you or your office; requiring payment for damage or discussing the damage will depend on the client.

Seductive Clients: Some therapists are obviously viewed by clients of either the same or opposite sex as potential lovers or mates and vice versa. The accusing therapist must keep in mind that seduction usually requires "two to tango." If one ignores seductive gestures, then in most cases they will cease. Some therapists may be overtly or subtly reinforcing flirtations on the part of clients. The therapist probably should first evalute his own behavior and begin to extinguish the client's flirtations. If this procedure does not work, then one might consider 1) confrontation or 2) termination and referral to another therapist. Also, the therapist who becomes overly involved emotionally with his clients loses his objectivity and usually becomes less effective therapeutically. This particular situation would probably warrant termination and referral.

Dealing with the Client's Friends and Relatives: The relationship between you and your client is confidential. Material discussed by the two of you should not be released to anyone unless the client gives his permission. Many times friends and/or relatives seeking information about your client are only interested in their own concerns and needs and have little interest in your client's welfare. If you receive such inquiries, you should keep your client informed unless the information might be upsetting to him.

Treating Personal Friends or Relatives: This complicated situation should usually be avoided. Being extremely close to the individuals involved, one tends to lose his objectivity. The therapist should attempt to refer the interested friend and/or relatives to another competent, respected therapist. Attempting to do therapy with close friends and relatives can be very destructive or disturbing to your personal relationships with them.

Summary

We have dealt with many and varied topics in this chapter which ranged from the first therapeutic encounter upto termination of the client. Also the "special problems" section was intended to better prepare the novice therapist for difficult situations which he will encounter. We have focused our attention on therapy; the next chapter looks at the possible alternatives to therapy.

CHAPTER VI

Alternatives to Individual Therapy

Alternatives to individual psychotherapy may be necessary for a variety of reasons: 1) the problem, 2) the personalities involved, or 3) a lack of therapeutic success. A therapist must be aware of the fact that he cannot and will not be all things to all people. There may be some point in time when the therapist must realize that his therapeutic method, personality, or his ability and willingness to help others simply is not enough. In some cases, a client may just need more than you have to offer therapeutically; while other clients simply "outgrow" the one-to-one relationship and must "stretch their wings." In our complicated society, individual therapy certainly is not a panacea for all of our society's psychological ills.

In order to realistically meet the needs of some clients, referral of those clients to other professionals or agencies may be mandatory. You as a therapist may not have the skills or the inclination to help certain clients. Often referral of a client to an agency or specialized group or person is a very beneficial adjunct to therapy which assists the client in his personal growth and development. Also the process of utilizing alternatives to therapy often can be "proof positive" to clients that they have really changed or improved. One example might be, referring a client to a vocational rehabilitation counselor may be proof to him that he has improved and is capable of fruitfully functioning in society.

Referral to appropriate alternative sources does not indicate that you are not doing your job. Rather, it may mean that: 1) you are a therapist who is interested in the growth of your client and are not retaining this client to meet your own particular needs; 2) you are attuned to the specifics of the client's problems and are ready to take alternative steps to help him resolve those problems; and 3) you are certainly interested in the client as a human being, not just as a case, and want what is best for him. The referral process merits your attention because it demonstrates how the whole process of exploration, understanding, and action, the primary cycle of therapy, can work, and in particular how the action phase can be brought to bear through the proper use of alternatives.

Which client groups need alternatives? There is not one particular group or individual who should always be referred to other sources, and no group or person should be so sterotyped. The privilege of referral definitely should not be abused, but unfortunately many therapists do. Referral should be first and foremost beneficial to the client. The act of referral must not be simply a means to rid oneself of undesirable clientele. Unfortunately, many therapists in core Appalachia characterize the uneducated mountain people as unfit for verbal therapy and frequently rid themselves of such clients too often via the chemotherapy route.

Agencies, institutions, or professional specialists are not the only sources which act as alternatives to individual psychotherapy. Other therapeutic techniques can also function as alternatives, such as:

(A) Chemotherapy - some clients must receive chemotherapy before any real therapeutic work can be undertaken.

(B) Group Therapy - the experiences with a group of other clients may often be quite educational and growth-promoting.

(C) Marital Therapy - it is often difficult to help a marriage survive if only one of the partners is seen.

(D) Family Therapy - when a family unit is disrupted, it seems logical to work with the system rather than to fractionate the family.

(E) Behavior Modification - can be a most efficient and effective approach with any individual when talking is not enough.

(F) Adlerian Approach - let us say an impasse has occurred, with this procedure a second therapist is added to the previously one-to-one situation; and a "mini group" is created. Often treatment and communication can be vastly improved.

This short list merely "skims the surface" regarding alternatives to individual therapy. In order to better understand what agencies, institutions, or groups would be considered good therapeutic alternatives, we have prepared some listings of services available for a variety of selected groups. These listings include resources which may or may not be in your particular community, and they should be used only as guidelines. Extra space is provided in each section in order that you might add other resources which might prove appropriate for particular groups.

Resources:

Abortion:

Planned Parenthood; State Bureau of Social Services; Health Clinics; Local Physicians; Private Abortion Services; or Clergy Consultation Services on Abortion.

Adoption:

State Bureau of Social Services; Child Welfare; Catholic Social Services; and Private National and/or International Adoption Services.

Alcoholism:

Community Houses for Alcoholics; Local Physicians; Local Psychiatrists; Alcoholics Anonymous; Community Mental Health Centers; Al-Anon; Alateen; National Council on Alcoholism; Volunteers of America; Veterans Administration; Hospital Alcoholism Clinics; Salvation Army; or Bureau of Rehabilitation Services

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Battered Children:

Police; Local Lawyers; Child Welfare; Community Mental Health Centers; Local Physicians; Local Psychiatrists; Children Protective Services; or Family Service Agencies.

Birth Control:

Planned Parenthood; Health Clinics; Local Physicians; Family Service Agencies; Vasectomy Service Centers.

Children and Adolescents:

Y.M.C.A.; Y.W.C.A.; Boys' Club; Campfire Girls; Job Corps; Help-Lines; 4-H Clubs; Child Welfare; Children Protective Services; Family Service Agencies; Mental Health Association; Specialized Clinics in Universities or Colleges; Local school systems; Big Brothers Association; Big Sisters Association; Community Mental Health Centers; Day Care Centers; Children's Counseling Centers; Bureau for Rehabilitation Services; Public Assistance; Foster Grandparents' Program; United Cerebral Palsy; Social Security; Sheltered Workshops; or Speech and Hearing Clinics.

Consumer Protection:

Better Business Bureau; Chamber of Commerce; State Consumer Protection Agency; Mayor's Office; Local Lawyers; or Local Media.

Day Care:

Religious Organizations; Family Service Agencies; Local Colleges or Universities; Local Child Care Organizations; Recreation Departments; or Private Day Care or Nursery Services.

Drug Abuse:

Police; Community Mental Health Centers; Bureau of Rehabilitation Services; Community Houses for Drug Abusers; Veterans' Administration; Drug and Poison Information Centers; Local Physicians; Local Psychiatrists; Local Colleges or Universities; Local Hospitals; State Psychiatric Hospitals; Narcotic Addiction Program; Goodwill Industries; Salvation Army; or "Help-Lines."

Education or Training:

Local School Systems; Adult Education Programs; Local Colleges or Universities; Vocational Schools; Bureau of Rehabilitation Services; Sheltered Workshops; Goodwill Industries; Job Corps; Bureau of Unemployment; or Salvation Army.

Family and/or Marriage Counseling:

Community Mental Health Centers; Planned Parenthood; Local Psychiatrists; Local Private Practitioners of Marriage Counseling; Family Service Agencies; or Religious Organizations.

Legal Aid:

City or State Bar Associations; Local Law Schools; Legal Aid Society; or Local Attorneys.

Mental Illness:

Mental Health Associations; Community Mental Health Centers; State Psychiatric Hospitals; Local Hospitals; Crisis Intervention Centers; Veterans' Administration; Bureau of Rehabilitation Services; Local Physicians; Local Psychiatrists; Goodwill Industries; "Help-Lines"; Organizations for Former Mental Patients; Half-Way Homes; Children's Psychiatric Centers; Special Educational Facilities; Big Brothers; Big Sisters; Religious Organizations; Bureau of Public Assistance; Social Security; Homes for Emotionally Disturbed Children; Local Colleges and Universities; or Family Service Agencies.

Mentally Retarded:

Bureau of Rehabilitation Services; Local Colleges or Universities; Community Houses for the Mentally Retarded; Local School Systems; Training Centers for the Trainable Retarded; Goodwill Industries; Speech and Hearing Clinics; Sheltered Workshops; Community Mental Health Centers; Social Security; Bureau of Public Assistance; or State Institutions for the Retarded.

Physical Difficulties:

Local Physicians; Local Hospitals; Physical Therapists; Speech and Hearing Clinics; Associations for the Blind; United Cerebral Palsy; Tuberculosis Control Programs; Veterans' Administration; Easter Seals; Kidney Foundations; American Cancer Society; American Heart Association; Diabetes Foundations; Bureau of Rehabilitation Services.

Runaways:

Police; Community Houses for Runaways; "Help-Lines"; or National Runaway Line - 800-621-4000.

Senior Citizens:

Homes for the Aged; Councils on Aging; Local Colleges or Universities; Soldiers' Relief Commission; Veterans' Administration; Religious Organizations; Local Physicians; Senior Citizens' Job Registry; Shut-In Society; Social Security; Bureau of Public Assistance; Local Hospitals; Community Mental Health Centers; or Local Community Centers.

Venereal Disease:

Local Health Departments; National Hotline - 800-523-1885; Local Physicians; Free Clinics for Venereal Disease; or Local "Help-Lines."

This is a relatively short listing of potential resources and each therapist should be responsible for familiarizing himself with the community resources, groups, institutions, or agencies available to him. The therapist should also become acquainted with the individuals working in the various agencies and institutions because often a great deal of "red tape" can be avoided when referral is necessary. Additionally, your acquaintances in these various sources of help may be more inclined to meet your client's needs in a more personal and timely manner.

In conclusion, the therapist must be immediately attuned to his client's needs. Remember that the whole idea of therapy is to assist the client to become a "fully functioning" individual. To begin or to continue individual therapy with some clients may just be what the client does not need, and referral of that case to another helping source may be the best action. If this procedure is used, then the therapist must be aware of potential helping sources and how to utilize them effectively.

CHAPTER VII

Summary

This guidebook has covered alot of therapeutic ground on primarily a practical level. The authors intended this as an eclectic work which would not necessarily stress a particular theoretical position. Most beginning therapists have some misgivings about their initial encounters with clients. We hope that this short manual can be quickly read, perhaps even a number of times, by the novice therapist for the purpose of instilling some feelings of confidence and ease. Our ideas concerning therapy have been shaped by many sources, such as articles, teachers, lectures, workshops, books, clients, employers, and fellow professionals. Your ideas and concepts concerning therapy will also be so shaped. You must remember that you should keep an open mind to such experiences for all may guide you to improving your therapeutic techniques.

The client and his dreams, goals, and/or biases should be somewhat clearer to you. Also that enigma known as the therapist and the "helping relationship" may not seem so mysterious now. We hope that you can now properly see the therapist as first and foremost a fallible human being who also has problems, hang-ups, and difficulties. From our discussion concerning therapy, we hope that you can now understand that therapy is a joint venture between client and therapist. You, as a therapist, are a catalyst, but the client must also be an active participant. Terminating and dealing with special problem situations are areas that most therapists will encounter and must be dealt with. We offered some suggestions for dealing with these situations or handling other problems through the use of therapeutic alternatives. We hope that we have focused on the practical for that was our intent.

Before this book is terminated, the authors wish to list some helpful hints relating to therapy. These items are based upon our experiences and may be somewhat repetitive. However, we believe that they are valuable enough to list.

1. Do not expect a 100% success rate. Some clients cannot or will not be or allow themselves to be helped. You should strive to help all clients, but do not berate yourself when you do not experience success with particular clients.
2. Attempt to leave your clients' problems at the office. You have your own problems, difficulties, family, and life to live. Divorce your office from your home.
3. Get away occasionally! Every therapist needs to get away from the never-ending barrage of problems and people seeking help. You will find that relaxation and rest can revitalize you.
4. If you are not tired when you get home, maybe you are not working. Therapy involves accurate empathy; feeling and experiencing the client's problems mentally. This process should be both physically and mentally draining. You as a therapist should be drained and tired after a day of

practicing therapy.

5. Go out of your way to continue your education through seminars, classes, or workshops. You never have enough knowledge, and the progressive therapist should strive to constantly grow educationally.
6. Attempt to be flexible! All clients and all situations do not reflect similar patterns. Remember that bending or changing procedures or rules may be necessary with some clients.
7. Coupled with number six would be examine your therapeutic techniques and be willing to change or modify where necessary.
8. Try to be as innovative and creative in therapy as possible! A novel approach may just be the catalyst needed.
9. Be willing to laugh at your own mistakes. Life is not so serious that one cannot experience some joy and humor.
10. Try and get your own head together and your life in order, or perhaps, "physician heal thyself!" If you are bringing a number of distracting personal problems to therapy, your sessions may not be as fruitful as you would like for them to be. If you need professional counseling then you should seek it.
11. Welcome suggestions or criticisms regarding your therapy. You will never be a perfect therapist, and some suggestions and/or criticisms can be helpful. Both may come from clients or colleagues.
12. When you are therapeutically "stumped" discuss your problems with a competent colleague. This practice does not reflect weakness; rather, it only proves that you are an interested, progressive therapist who is concerned about his effectiveness.
13. When you think that you have got all the answers or you are the greatest therapist in the world, you are probably out of touch with reality.

Becoming and functioning as a "good" therapist are not easy procedures. Both require alot of hard work and effort. Good luck in your future endeavours. You will need some luck, but primarily alot of hark work.

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